AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

MEDICAL BANKRUPTCY FAIRNESS ACT

HEARING

BEFORE THE

SUBCOMMITTEE ON
COMMERCIAL AND ADMINISTRATIVE LAW

OF THE

COMMITTEE ON THE JUDICIARY
HOUSE OF REPRESENTATIVES

ONE HUNDRED ELEVENTH CONGRESS

SECOND SESSION

ON

H.R. 901

JULY 15, 2010

Serial No. 111–141

Printed for the use of the Committee on the Judiciary

Available via the World Wide Web: http://judiciary.house.gov

U.S. GOVERNMENT PRINTING OFFICE

57–432 PDF WASHINGTON : 2010

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

COMMITTEE ON THE JUDICIARY

JOHN CONYERS, JR., Michigan, *Chairman*

HOWARD L. BERMAN, California
RICK BOUCHER, Virginia
JERROLD NADLER, New York
ROBERT C. "BOBBY" SCOTT, Virginia
MELVIN L. WATT, North Carolina
ZOE LOFGREN, California
SHEILA JACKSON LEE, Texas
MAXINE WATERS, California
WILLIAM D. DELAHUNT, Massachusetts
STEVE COHEN, Tennessee
HENRY C. "HANK" JOHNSON, JR., Georgia
PEDRO PIERLUISI, Puerto Rico
MIKE QUIGLEY, Illinois
JUDY CHU, California
TED DEUTCH, Florida
LUIS V. GUTIERREZ, Illinois
TAMMY BALDWIN, Wisconsin
CHARLES A. GONZALEZ, Texas
ANTHONY D. WEINER, New York
ADAM B. SCHIFF, California
LINDA T. SÁNCHEZ, California
DANIEL MAFFEI, New York
JARED POLIS, Colorado

LAMAR SMITH, Texas
F. JAMES SENSENBRENNER, JR., Wisconsin
HOWARD COBLE, North Carolina
ELTON GALLEGLY, California
BOB GOODLATTE, Virginia
DANIEL E. LUNGREN, California
DARRELL E. ISSA, California
J. RANDY FORBES, Virginia
STEVE KING, Iowa
TRENT FRANKS, Arizona
LOUIE GOHMERT, Texas
JIM JORDAN, Ohio
TED POE, Texas
JASON CHAFFETZ, Utah
TOM ROONEY, Florida
GREGG HARPER, Mississippi

PERRY APELBAUM, *Majority Staff Director and Chief Counsel*
SEAN MCLAUGHLIN, *Minority Chief of Staff and General Counsel*

SUBCOMMITTEE ON COMMERCIAL AND ADMINISTRATIVE LAW

STEVE COHEN, Tennessee, *Chairman*

WILLIAM D. DELAHUNT, Massachusetts
MELVIN L. WATT, North Carolina
DANIEL MAFFEI, New York
ZOE LOFGREN, California
HENRY C. "HANK" JOHNSON, JR., Georgia
ROBERT C. "BOBBY" SCOTT, Virginia
JOHN CONYERS, JR., Michigan
JUDY CHU, California

TRENT FRANKS, Arizona
JIM JORDAN, Ohio
HOWARD COBLE, North Carolina
DARRELL E. ISSA, California
J. RANDY FORBES, Virginia
STEVE KING, Iowa

MICHONE JOHNSON, *Chief Counsel*
DANIEL FLORES, *Minority Counsel*

CONTENTS

JULY 15, 2010

Page

THE BILL

H.R. 901, the "Medical Bankruptcy Fairness Act" 3

OPENING STATEMENTS

The Honorable Steve Cohen, a Representative in Congress from the State of Tennessee, and Chairman, Subcommittee on Commercial and Administrative Law 1
The Honorable John Conyers, Jr., a Representative in Congress from the State of Michigan, Chairman, Committee on the Judiciary, and Member, Subcommittee on Commercial and Administrative Law 8
The Honorable Daniel Maffei, a Representative in Congress from the State of New York, and Member, Subcommittee on Commercial and Administrative Law 13
The Honorable Trent Franks, a Representative in Congress from the State of Arizona, and Ranking Member, Subcommittee on Commercial and Administrative Law 13
The Honorable William D. Delahunt, a Representative in Congress from the State of Massachusetts, and Member, Subcommittee on Commercial and Administrative Law 15
The Honorable Henry C. "Hank" Johnson, Jr., a Representative in Congress from the State of Georgia, and Member, Subcommittee on Commercial and Administrative Law 15
The Honorable Steve King, a Representative in Congress from the State of Iowa, and Member, Subcommittee on Commercial and Administrative Law 17
The Honorable Melvin L. Watt, a Representative in Congress from the State of North Carolina, and Member, Subcommittee on Commercial and Administrative Law 17
The Honorable Howard Coble, a Representative in Congress from the State of North Carolina, and Member, Subcommittee on Commercial and Administrative Law 18
The Honorable Robert C. "Bobby" Scott, a Representative in Congress from the State of Virginia, and Member, Subcommittee on Commercial and Administrative Law 20
The Honorable Judy Chu, a Representative in Congress from the State of California, and Member Subcommittee on Commercial and Administrative Law 22

WITNESSES

The Honorable Cecelia G. Morris, United States Bankruptcy Judge, Southern District of New York
Oral Testimony 85
Prepared Statement 88
Ms. Aparna Mathur, Ph.D., Resident Scholar, American Enterprise Institute
Oral Testimony 96
Prepared Statement 99

Page

Mr. Peter S. Wright, Jr., Director of Clinical Programs, Consumer and Commercial Law Clinic, Franklin Pierce Law Center
Oral Testimony 120
Prepared Statement 122

LETTERS, STATEMENTS, ETC., SUBMITTED FOR THE HEARING

Prepared Statement of the Honorable John Conyers, Jr., a Representative in Congress from the State of Michigan, Chairman, Committee on the Judiciary, and Member, Subcommittee on Commercial and Administrative Law 9
Material submitted by the Honorable Steve Cohen, a Representative in Congress from the State of Tennessee, and Chairman, Subcommittee on Commercial and Administrative Law 25
Prepared Statement of the Honorable Henry C. "Hank" Johnson, Jr., a Representative in Congress from the State of Georgia, and Member, Subcommittee on Commercial and Administrative Law 83
Material submitted by the Honorable Trent Franks, a Representative in Congress from the State of Arizona, and Ranking Member, Subcommittee on Commercial and Administrative Law 142

APPENDIX

MATERIAL SUBMITTED FOR THE HEARING RECORD

Response to Post-Hearing Questions from the Honorable Cecelia G. Morris, United States Bankruptcy Judge, Southern District of New York 185
Response to Post-Hearing Questions from Aparna Mathur, Ph.D., Resident Scholar, American Enterprise Institute 189
Response to Post-Hearing Questions from Peter S. Wright, Jr., Director of Clinical Programs, Consumer and Commercial Law Clinic, Franklin Pierce Law Center 191

MEDICAL BANKRUPTCY FAIRNESS ACT

THURSDAY, JULY 15, 2010

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON COMMERCIAL
AND ADMINISTRATIVE LAW,
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The Subcommittee met, pursuant to notice, at 11:32 a.m., in room 2141, Rayburn House Office Building, the Honorable Steve Cohen (Chairman of the Subcommittee) presiding.

Present: Representatives Cohen, Conyers, Delahunt, Watt, Maffei, Johnson, Scott, Chu, Franks, Coble, and King.

Staff present: (Majority) James Park, Counsel; Adam Russell, Professional Staff Member; and Daniel Flores, Minority Counsel.

Mr. COHEN. This hearing of the Committee on the Judiciary, Subcommittee on Commercial Administrative Law will now come to order. Without objection, the Chair will be authorized to call a recess of the hearing. I will recognize myself for a short statement.

Today we will revisit the issue of medical debt as a contributor to bankruptcy. Last year the Subcommittee held a hearing on this issue focusing on a Harvard study in 2007 on nationwide filing for bankruptcy. Disturbingly, that study concluded that 62.1 percent of bankruptcy debtors can trace at least part of the cause of their bankruptcies to medical debt. The 2007 data also indicates that there was a 49.6 percent increase in medical bankruptcies as a proportion of bankruptcy filings between 2001 and 2007.

Three years ago this Subcommittee held a hearing on a predecessor Harvard study, which examined the 2001 bankruptcy filing data inside select judicial districts around the country. That study concluded that illness or high medical bills contributed to almost half of all the bankruptcy filings that were studied.

The study further suggests that medical debt was driving middle-class families into bankruptcy. Of these classified in this study as medically bankrupt, more than 60 percent had attended college, more than 66 percent at one point owned a home, and 78 percent had health insurance at the time they became sick or injured.

H.R. 901, the "Medical Bankruptcy Fairness Act," introduced by Representative Carol Shea-Porter of New Hampshire, represents an important step forward to addressing this problem of debtors forced into bankruptcy because of overwhelming health care costs. This legislation would increase the Federal homestead exemption to $250,000, and if state law requires that a debtor claim a lower

state law homestated exemption, it allows the debtor to nonetheless choose the higher Federal homestead exemption.

These measures would allow a debtor who was forced into bankruptcy because of high medical debt to protect his or her interest in their home from being transferred into the bankruptcy estate and sold or liquidated. They would also provide some peace of mind for medically distressed debtors, who have enough to worry about without also having to wonder whether their hard-earned home equity will be lost because of accident or illness.

H.R. 901 would also exempt medically distressed debtors from the Chapter 7 means test. Other Subcommittee Members and I are on record as being critical of the means test and other provisions of Bankruptcy Abuse Prevention and Consumer Protection Act of 2005, otherwise known as BAPCCA, or something like that—BAPCPA—BAPCPA.

The unnecessary expense and burden that it places on debtors should not be placed upon those who seek bankruptcy relief because of medical costs or loss of income associated with providing care. In 2005, BAPCPA supporters pointed to a Department of Justice court record analysis that concluded the majority of the sample had no medical debt at all; that among those with medical debt, the average medical debt was under $5,000 and medical debt comprised only 5.5 percent of the total unsecured debt of the sample.

A recent Law Review article examined the Department of Justice analysis and concluded that the protocol used by the DOJ, which relied solely on documents filed by debtors in connection with the bankruptcy cases "produced a skewed undercount of medical bills and failed to account for bankruptcy filers with significant medical hardship, who had no debt on Schedule F that could be identified as medical."

As the authors of the Law Review article noted, the clock cannot be turned back to 2005, when the Dow Jones—excuse me—the Department of Justice analysis enabled lawmakers to vote with a clear conscience in favor of BAPCPA and against amendments that Members of Congress proposed to protect people with medical problems from certain harsher effects of the bill.

H.R. 901 is a critical first step in correcting this legislative oversight by restoring balance for medically distressed individuals facing financial ruin. I thank Representative Shea-Porter for introducing H.R. 901 that brings together two of the most important issues that this Congress and America has faced recently, which is our lack of a national health care policy, which we rectified this past year, an historic vote taken in by mostly, almost entirely, Democrats, and the terrible home foreclosure crisis that continues to ravage and wreck this country and take people into terrible bankruptcies and debt caused by years and years of neglect during the previous Administration.

And I thank our witnesses for their participation today.

[The bill, H.R. 901, follows:]

I

111TH CONGRESS
1ST SESSION

H. R. 901

To amend title 11 of the United States Code to provide protection for medical debt homeowners, to restore bankruptcy protections for individuals experiencing economic distress as caregivers to ill or disabled family members, and to exempt from means testing debtors whose financial problems were caused by serious medical problems.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 4, 2009

Ms. SHEA-PORTER introduced the following bill; which was referred to the Committee on the Judiciary

---

A BILL

To amend title 11 of the United States Code to provide protection for medical debt homeowners, to restore bankruptcy protections for individuals experiencing economic distress as caregivers to ill or disabled family members, and to exempt from means testing debtors whose financial problems were caused by serious medical problems.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Medical Bankruptcy Fairness Act".

SEC. 2. DEFINITIONS.

Section 101 of title 11, the United States Code, is amended—

(1) by inserting after paragraph (39A) the following:

"(39B) the term 'medically distressed debtor' means a debtor who, in any consecutive 12-month period during the 3 years before the date of the filing of the petition—

"(A) incurred or paid medical expenses for the debtor or a dependent of the debtor that were not paid by any third party payor and were in excess of the lesser of—

"(i) 25 percent of the debtor's household income for such 12-month period; or

"(ii) $10,000.

"(B) was a member of a household in which 1 or more members (including the debtor) lost all or substantially all of the member's employment or business income for 4 or more weeks during such 12-month period due to a medical problem of a member of the household or a dependent of the debtor; or

"(C) was a member of a household in which 1 or more members (including the debtor) lost all or substantially all of the member's

alimony or support income for 4 or more weeks during such 12-month period due to a medical problem of a person obligated to pay alimony or support.".

SEC. 3. EXEMPTIONS.

(a) EXEMPT PROPERTY.—Section 522 of title 11, the United States Code, is amended by adding at the end the following:

"(r) For a debtor who is a medically distressed debtor, if the debtor elects to exempt property—

"(1) listed in subsection (b)(2), then in lieu of the exemption provided under subsection (d)(1), the debtor may elect to exempt the debtor's aggregate interest, not to exceed $250,000 in value, in real property or personal property that the debtor or a dependent of the debtor uses as a residence, in a cooperative that owns property that the debtor or a dependent of the debtor uses as a residence, or in a burial plot for the debtor or a *dependent* of the debtor; or

"(2) listed in subsection (b)(3), then if the exemption provided under applicable law specifically for such property is for less than $250,000 in value, the debtor may elect in lieu of such exemption to exempt the debtor's aggregate interest, not to exceed

$250,000 in value, in any such real or personal property, cooperative, or burial plot.".

(b) CONFORMING AMENDMENTS.—Sections 104(b)(1) and 104(b)(2) of title 11, the United States Code, are amended by inserting immediately after "522(q)," "522(r),".

SEC. 4. DISMISSAL OF A CASE OR CONVERSION TO A CASE UNDER CHAPTER 11 OR 13.

Section 707(b) of title 11, the United States Code, is amended by adding at the end the following:

"(8)(A) No judge, United States trustee (or bankruptcy administrator, if any), trustee, or other party in interest may file a motion under paragraph (2) if the debtor is a medically distressed debtor or an economically distressed caregiver.

"(B) In this paragraph, the term 'economically distressed caregiver' means a caregiver who, within 3 years before the date of the filing of the petition—

"(i) experienced a downgrade in employment status that correlates to a reduction in wages, work hours, business income or results in unemployment, to care for a relative for not less than 30 days; or

"(ii) in any consecutive 12-month period, has incurred or paid medical expenses on behalf

of a relative that were not paid by any third party payor and were in excess of the lesser of—

"(I) 25 percent of the debtor's household income for such 12-month period; or

"(II) $10,000.".

SEC. 5. EFFECTIVE DATE; APPLICATION OF AMENDMENTS.

(a) EFFECTIVE DATE.—Except as provided in subsection (b), this Act and the amendments made by this Act shall take effect on the date of the enactment of this Act.

(b) APPLICATION OF AMENDMENTS.—The amendments made by this Act shall apply only with respect to cases commenced under title 11 of the United States Code on or after the date of the enactment of this Act.

○

Mr. COHEN. I now recognize my colleague, Mr. Franks, who is not here, but I would recognize Mr. Coble, if he would like to take his moment in the limelight in lieu thereof, in place thereof.

Mr. COBLE. Thank you, Mr. Chairman. I am told that the Ranking Member from Arizona is en route, so I will waive any opening statement.

Mr. COHEN. Thank you.

We will then put in reserve the opportunity for Mr. Franks, the distinguished Ranking Member, to make his opening remarks. I would now like to recognize Mr. Conyers, the most esteemed, distinguished and erudite Chairman of this Committee, for any opening remarks he would like to add.

Mr. CONYERS. Thank you, Mr. Chairman.

For the benefit of our friends that are here today, that is a very expansive introduction that I get from him on a regular basis.

The only thing I wanted to do was to welcome Dr. Mathur today—she has testified before us—and also to welcome, extend a welcome, to her parents, who are here as well. We are proud of your daughter, except in one respect. And that is that she is still questioning the fact that 60 percent of all bankruptcies are created by medical indebtedness.

Now, this is not the most complicated issue that has ever been before the Committee, and the 60 percent figure is affirmed by all—well, almost everyone except our witness today, Dr. Mathur herself. And so what we are trying to do is to persuade her that everybody else isn't wrong.

And I don't think that that would be too hard a subject with all my distinguished friends, Mr. Chairman. And so I ask unanimous consent to put my statement into the record.

Mr. COHEN. Without objection, it will be done.

[The prepared statement of Mr. Conyers follows:]

Statement of the Honorable John Conyers, Jr.
for the Hearing on

H.R. 901, the "Medical Bankruptcy Fairness Act"

Before the Subcommittee on Commercial and Administrative Law

Thursday, July 15, 2010, at 11:00 a.m.
2141 Rayburn House Office Building

Last July, this Subcommittee conducted a hearing on whether our Nation's health care system was bankrupting Americans. During the course of that hearing, we learned that *more than 60%* of consumer bankruptcy cases filed in 2007 were prompted by significant medical debt.

This startling statistic, we must remember, reflects conditions that existed *before* the onset of the ongoing recessionary crisis and a current national unemployment rate of nearly 10%.

I have long known that many hardworking men and women in the United States are just one major illness or accident away from financial disaster. This precarious reality affects not only the uninsured, but even those who have full medical insurance benefits.

This is why I introduced H.R. 676, the "United States Nation Health Care Act," legislation that would have established universal health care for all Americans through a single-payer national health insurance system.

Although I am disappointed that Congress never seriously considered such a single-payer system during the recent health care reform debate, I am heartened that we took a big step toward remedying the many defects of our health insurance system earlier this year with the enactment of the Patient Protection and Affordable Care Act and the Health Care and Reconciliation Act of 2010.

I am also glad that some portions of these laws have already taken effect.

But many other provisions will not be implemented until 2014 and beyond.

Meanwhile, many of our most financially vulnerable citizens continue to be saddled with crushing medical debt loads.

Accordingly, I commend my colleague from New Hampshire, Representative Carol Shea-Porter, for introducing H.R. 901, the "Medical Bankruptcy Fairness Act."

This bill represents a modest but important step in addressing the problem of medical debt that forces honest, hardworking families into bankruptcy.

As we consider the merits of Representative Shea-Porter's bill, I would like to make three observations.

First, a critical aspect of H.R. 901 is that it would help medically distressed debtors retain their homes in bankruptcy, by increasing the federal homestead exemption and allowing all medically distressed debtors to take advantage of this increased exemption, regardless of where they live.

Specifically, the bill would increase the federal homestead exemption for medically distressed debtors from $21,625 to $250,000.

And if applicable State law requires a debtor to claim State law exemptions rather than federal bankruptcy exemptions, the bill would override State law and allow a medically-distressed debtor to claim the new $250,000 federal exemption.

This means that a medically-distressed homeowner will not be forced to turn over to a bankruptcy trustee the hard-earned equity – up to a maximum of $250,000 in his or her home – to pay the claims of creditors.

In most other industrialized countries, such relief would not be necessary.

Medical debt and medical bankruptcies are uniquely American phenomena.

Medical bankruptcies are a by-product of our profit-based health care financing system, the skyrocketing and unsustainable costs that result, and the failure of our private insurance system to provide adequate protection to those it insures. It is a national shame.

Second, we need to consider how the provisions of the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 impact medically distressed debtors.

It is no secret that I adamantly opposed those so-called bankruptcy law "reforms" over the seven-plus years they were under consideration in Congress.

As a result of these new hurdles placed in the way of financially distressed Americans, it looks like some of my worst fears may have come true.

For example, as a result of the 2005 amendments, families forced into bankruptcy because of overwhelming health care costs – through no fault of their own – must now prove their eligibility for relief through a burdensome means test, for which one form alone asks *57 questions* about financial circumstances.

H.R. 901 addresses this burden by exempting medically distressed debtors and economically distressed care-givers from the onerous means test requirements that often end up catching the unwary but honest debtor.

Since its enactment, the means test has served to dissuade even families in severe distress from even seeking Chapter 7 relief, by adding expense and complexity to the process of filing for bankruptcy.

To be frank, I would prefer the means test to be repealed altogether.

At any rate, Congress has seen fit to waive the means test requirement for

certain types of debtors – like members of the National Guard, and armed forces reservists called to active duty – when public policy makes it appropriate to do so.

Those forced to the brink of bankruptcy because of overwhelming medical costs seem to me to be equally entitled to such relief.

Third, I want to stress that we must act quickly.

The problem of high health care costs is not going away soon. More than three-quarters of the medically bankrupted had insurance at the time they became ill, and that almost half of all consumer bankruptcy cases stemmed at least in part from medical debt.

These were people who thought they were financially protected. But when disaster struck, they learned that their defective insurance policies did not offer true protection.

With record unemployment and underemployment, the continuing home foreclosure crisis, and the fact that millions of Americans have lost substantial amounts of their savings, that percentage can only have grown higher.

Congress must not delay in enacting H.R. 901.

I thank our witnesses for their participation in today's hearing, and encourage them to share their thoughts about this legislation, and other ways to improve our bankruptcy law for those facing overwhelming medical debt.

Mr. COHEN. And the Chair of the Subcommittee likewise recognizes Dr. Mathur and her parents. And even if one person may be considered wrong, one woman with courage. And there is something else that follows it up, I think.

Is there anybody else who would like to make an opening statement or recognize any of the other panelists or their parents?

Mr. Maffei, you are recognized.

Mr. MAFFEI. Thank you, Mr. Chairman. I will be very brief. But I do appreciate the Subcommittee having this hearing.

It is clear that medical bankruptcy is reaching epidemic proportions. Whatever the percentage is, it continues to be a huge problem in my district, and the percentage does seem to continue to rise in this squeeze, where family budgets are shrinking and yet medical costs continue to skyrocket. It seems to be affecting more seniors in my district.

The other thing—just a note in my district, we have not had the kind of home foreclosure crisis in the rest of the country, mainly because we haven't seen the big bubble, so our bubble never burst in terms of home foreclosures. So most of the plurality of the bankruptcies coming that are actually affecting regular people are because of medical costs. And often these are people who have insurance.

And so that is the other point I would make is that while clearly we made a step in the right direction in our health care actions in this Congress, we are still going to have this problem into the future.

Whether Ms. Shea-Porter's bill is the answer or something else, I am not sure. I will proceed to this hearing without prejudice about that, but clearly something is necessary to address it.

And it is my feeling, just to conclude, that given that the overall costs of health care tend to involve five basic chronic conditions, and not necessarily catastrophic illness, is that it seems that this is a problem that should have a solution.

But, you know, look, if we pool all of our risk together, we should be able to find a way to be able to make sure that families don't go bankrupt in the relatively rare instance where they have these catastrophic diseases. And yet, of course, to that family it is huge.

And my last point, you know, given when a family faces very difficult illness of a loved one, the last thing that we should do as a society is then put on top of that this incredible financial burden and the possibility of losing their home and et cetera.

And so whatever we can do on this, I appreciate the panelists coming to testify. Thank you very much.

Mr. COHEN. Thank you, Mr. Maffei.

I would now like to recognize the distinguished Ranking Member of the Subcommittee, the gentleman from Arizona, Mr. Franks, for his opening statement.

Mr. FRANKS. Well, thank you, Mr. Chairman. I apologize. I just got back from votes, but I got there a little late, so that made me late here. But thank you.

Mr. Chairman, in July 2009 this Subcommittee held a hearing on whether medical debt was bankrupting Americans. And the conclusion was that the answer was no. The evidence continues to support that answer today, and there is thus no need for the legislation that is the subject of today's hearing. And I am surprised that the biggest piece of news since our hearing has not convinced my colleagues on the other side of the aisle of that conclusion.

The big news was, of course, Obamacare. Obamacare was pitched to the American people as the magical legislation that would increase coverage and simultaneously decrease costs. It was the silver bullet that would somehow protect Americans from rising medical costs while spending at least a trillion of those same Americans' dollars.

Of course, the American people didn't believe that sales pitch, Mr. Chairman. The majority of them today want Congress to repeal Obamacare. Instead of being a silver bullet, they believe Obamacare is proving itself to be a lead balloon.

That being said, every one of my colleagues on the other side of the aisle today voted for Obamacare. Is today's hearing the other party's admission that Obamacare won't work? Are my colleagues worried that the millions who will lose their medical insurance of their choice under Obamacare will be bankrupted by the effect of that legislation?

Are my colleagues worried that small business owners, who face higher insurance benefit costs and higher Medicare taxes under Obamacare, will be forced into bankruptcy because of it? Or are my colleagues worried that the $569 billion in new health care taxes, taxes that violate the President's promise not to raise taxes on the middle class, will threaten individuals and small business owners with bankruptcy?

Are my colleagues worried that the $311 billion in rising health care costs under the Obamacare that the Department of Health and Human Services' own actuaries identified will bankrupt Americans, who will have to pay for that?

Now, I don't see those issues addressed specifically in today's bill, and I wonder if one of my colleagues could point me to where they are addressed. Of course, perhaps they are not addressed at all, Mr. Chairman, because Obamacare supporters have steadfastly refused to admit that realities like these exist.

In a rose-colored world painted by Obamacare's backers, oppressive medical debts that bankrupted Americans and American businesses were supposed to become a thing of the past. They weren't supposed to become permanent features of the landscape that meant we had to pass medical debt bankruptcy legislation.

Now, Mr. Chairman, let me just close by a couple of comments. Under this legislation as it is written, if I went out and ran my credit cards up to $50,000, all I would have to do to get rid of those would be to go out and run my health care costs up to $10,000 and then wipe the entire $60,000 clean. And that puts the situation beyond even the ostensible scope of this legislation.

And I guess I have to suggest in the context, you know, a little over a week ago, this country had a 1-day deficit—1 day—of $166 billion. Now, that is larger than the entire 2007 deficit. That is the last time Republicans totally controlled the budget process for the entire year, and yet in 1 day under the Obama administration, we have raised that more than we did in an entire year under the last Republican-controlled process.

And, of course, that is $20 billion more than Obamacare was supposed to save over 10 years. And, of course, I would just say, and finally, you know, I want so much. I mean, I have had 16 surgeries, and my parents were burdened with incredible medical challenges

when I was a little baby, and I want you to know that I identify so much with the people that deal with these kinds of things.

But under this situation in the final analysis, the socialized approaches and these things that just simply ignore the laws of mathematics end up hurting more people, and usually the ones that need it most in the long run. And I am just suggesting to you that if we don't start recognizing realities here, we are going to hurt everybody in the country. And the people at the bottom rung of the economic ladder are going to be hurt the worst.

And so with that, Mr. Chairman, I just wonder where it will all end and yield back.

Mr. COHEN. Mr. Johnson, you are——

Mr. Delahunt, do you seek—appreciate your——

Mr. DELAHUNT. Yes, I would be very brief, Mr. Chairman. Thank you.

I just want to remind my good friend from Arizona that the financial collapse that has immersed us into this economic quagmire occurred in September of 2008. We all remember the panic, the concern and the uncertainty. It was devastating. It will take time to emerge.

I believe we are heading in the right direction. There are some pieces of light that are piercing the darkness. But let us not forget—and I don't want to make this partisan, but clearly the Ranking Member refers to Obamacare and people on the other side of the aisle, and I have got respect for him, and I know he is very sincere when he expresses his empathy and sympathy for people who find themselves in this situation.

But I also can't let go without some rejoinder that it was a Republican administration and a Republican Congress that is responsible for policies that led us to the disaster that we saw consume us in September of 2008.

We can talk about the deficit. Every night during special orders, or every other night, I spoke to that deficit. It is a Republican deficit. Let us understand that. That is really what it is. That is what we inherited when President Obama came to office and a new majority came to both the House and the Senate.

We landed on a ship of state that could best be described as the Titanic in economic terms. We managed to steer and scrape the iceberg. We still have some shoals that have to be navigated. But where we are today is the result of the Bush-Cheney administration that received overwhelming support from Republicans in both the House and the Senate. And with that, I yield back.

Mr. COHEN. Thank you, sir.

Does anybody else seek recognition?

Mr. Johnson of Georgia?

Mr. JOHNSON. Thank you, Chairman, for holding this hearing on the Medical Bankruptcy Fairness Act. And fairness is so important, as we adjust the scales from my colleagues on the other side's predisposition to always support the big business over consumers.

And, you know, I mean, it was my friend on the other side of the aisle fought with the vengeance of a mother whose child was under attack like a bear, a mama bear trying to take care of her cubs, fought so hard to keep the bankruptcy laws as they are so that people, say, like my friend, my good friend John McCain, who forgot

how many houses that he owned—it was about seven, I believe—and fought hard to make it legal for him to be able to select which of those seven houses he is going to declare as his residence under bankruptcy, should something happen and he would have to file.

And they can get the mortgage totally reworked on the other six homes of his choosing. They can—that beach home, the chalet in Vail, you know, the Florida, Miami, you know, seaside villa, the Arlington, Virginia, condo, the Ritz-Carlton condo in D.C., whatever the case—just take one of those and if you get into trouble, you can turn yourself right-side up in bankruptcy. You can get your balance reduced to what the home is worth now, as opposed to what it was when you took out the.

And they fought so hard for that, and they fought hard to maintain the right of those folks with the six and seven homes to be able to get their interest rate reduced, should the need arise. But they fought so hard against just allowing consumers to be able to—with the only home that they have—to have that debt restructured.

And so I am not surprised at the righteous indignation that has been on display today from my friend on the other side of the aisle and I mean, you know, folks calling BP, apologizing to BP, and then calling financial regulatory reform an ant, you know. These things are just—it is part of a clear pattern of supporting big business over consumers.

And I am glad that we are having this hearing today, Mr. Chairman, because this gives the Members the opportunity to explore whether the Medical Bankruptcy Fairness Act is a tool that should reform the bankruptcy code to respond to the needs of distressed medical debtors, most of whom are just working people, just ordinary consumers.

And I applaud the Chairman for exploring the solutions to the overall problem of rising medical debt. According to the IXIS project in 2007, the most recent year for which data are available, an estimated 72 million Americans have medical bill problems. Many of these Americans made paying off medical bills a top priority, and therefore struggled to pay for other basic necessities like food, rent, clothing and the mortgage note.

According to that report, more than 30 million American adults used about all their savings or borrowed against their homes in order to pay off medical bills. This, however, did not stop the bill collector from knocking on their door if they came up short.

According to a June 2009 American Journal of Medicine study, 62 percent of all bankruptcies filed in 2007 were linked to medical expenses. And of those who filed for bankruptcy in 2007, nearly 80 percent had health insurance.

And so that is why I like to refer to the medical care reform not as Obamacare, as it is derisively referred to by my colleagues on the other aisle, singing from a script in unison, not even in harmony, but in unison, and that is why I like to refer to medical care reform as medical insurance reform. And they love to protect those insurance companies also.

According to the same study, most medical debtors were well-educated and middle-class. Due to the recent recession and record unemployment, more and more Americans cannot afford health insurance. Last year Families USA released a report that showed

nearly 3 million people under the age of 65 in my home state of Georgia were uninsured at some point in 2007 or 2008.

This session Congress scored a historic victory in the century-long battle to reform the Nation's broken health care system. Passing health care reform will definitely improve the situation, but a number of the provisions do not kick in until 2014. Thus, medical debt is a problem that must be adequately addressed.

I hope this hearing will give us all the opportunity to understand the serious consequences that medical debt has on our constituents, and I look forward to hearing the witnesses' views on how Congress can solve this problem.

Thank you, Mr. Chairman, and I yield back the balance of my time.

Mr. COHEN. Thank you, Mr. Johnson. I appreciate your warming Mr. King up. I imagine Mr. King is ready.

Now on deck, the next batter will be from Iowa, Mr. Steve King.

Mr. KING. Thank you, Mr. Chairman. Appreciate the testimony of the witnesses, and I regret that I wasn't here to hear it all, but, of course, it is a matter of record.

And I would like to first just explore something. I am always interested in foundational things that we do and turn to Judge Morris, because I know she will know this, as this is a completely simple softball question. Where does the Federal Government get the authority to control bankruptcy?

Judge MORRIS. Constitution.

Mr. KING. Thank you. I knew you would know the answer right away. And so when I look at Article I, Section 8, it says that the Congress shall have the power to—excuse me.

Oh, excuse me.

Mr. COHEN. Would the clerk make note that Judge Morris answered the first question correctly? Our second question?

Mr. KING. Well, thank you, Mr. Chairman. I have just been advised that I came in—this is for an opening statement invitation, rather than questioning the witnesses, so as I listened to Mr. Johnson, I got the wrong impression. And so what I will do instead is say that I will be interested in the testimony of the witnesses here and looking forward to hearing that and evaluating that testimony. And I would be happy to ask those questions at the appropriate time. Thank you. And I yield back.

Mr. COHEN. You are welcome, Mr. King.

Mr. Watt, you are recognized.

Mr. WATT. Mr. Chairman, I was trying to stay out of this very partisan debate but I was just going to try to give some content to Mr. Delahunt's statement.

I was feverishly looking through my BlackBerry, because for months and months and months I kept in my BlackBerry a magic date back in September of 2008 on which on a Friday afternoon at 3:30 in the afternoon, 185 members of our Democratic caucus were on a nationwide conference call about the impending meltdown that was about to occur in our economy.

And I was trying to recall whether President Obama—he wasn't President at that time—was on that call. And I recall that he specifically was not. That call was with Secretary of the Treasury Paulson in the Bush administration, the chairman of the Federal

Reserve, Chairman Bernanke, and the leadership. And we were advised that a similar call had taken place earlier that day with members of the Republican conference to advise them of the dire straits that our economy we are in.

And as best I recall that—as best I recall that conversation—and I am trying to be equal about this; this not, you know, I just want the record to be square about where we were at that time—it was Secretary Paulson, a member of the Bush administration, who likened the condition of our country at that time to what could, according to him, become worse than the condition that we faced in the Great Depression unless we took dramatic action to address that.

So my good friend from Arizona needs to understand that all of these things take place in an historic context, that this situation in which we find ourselves didn't just all of a sudden happen one day when President Obama became President of the United States or didn't happen one day when we passed what he characterizes as Obamacare. There is historical context to this economic meltdown.

There is also historical context to the deficit in which we find ourselves, because I happened to be here and took one of the very difficult votes in 1993 or 1994 that people attribute to the Republican majority becoming a reality in 1994, a very difficult vote for a number of members of our caucus, but a vote which led to, by the end of the Clinton administration, a surplus in our Federal budget projected out as far as the human eye could see.

It took almost that whole 8-year term of the Clinton administration to get us there. This is a process. I am confident that we are moving in the right direction, and we will be a lot closer at the end of the Obama administration, either 2 years from now or 6 years from now, than we were at the end of the Bush administration.

But we need to put this in historical context, that the Clinton administration left the Bush administration with a serious surplus projected as far as out into the future as we could and that within 6 months after the Bush administration started, we were back into a deficit situation.

So we can be partisan about this. I try not to be partisan about our economy. To be honest with you, you know, our economy is something that should be above politics. Our national defense should be above politics or partisanship. So I just want to set the record straight that there are some historical facts that exist here in which we are operating.

And with that, Mr. Chairman, I yield back.

Mr. COBLE. Mr. Chairman?

Mr. COHEN. Do I hear a voice from North Carolina? Another voice from North Carolina?

Mr. COBLE. A brief voice.

Mr. COHEN. Mr. Coble, you are recognized, and you are respected and appreciated.

Mr. COBLE. Thank you, sir. I am going to insert my oars into these partisan waters.

There is nothing wrong with being partisan, by the way. But I think during the time that Mr. Watt referred to during the Clinton administration, the surplus, I believe a good part of that time there

was a Republican majority, at least in the House. So I think we need to have some credit for that as well.

Mr. WATT. If the gentleman will yield, I am happy to give whoever voted for the turnaround the credit that they deserve. My recollection there was not a—there were maybe two or three people who on your side who voted for it, but I think the turnaround occurred in a Democratic majority House——

Mr. COBLE. Well, this is my time.

Mr. WATT [continuing]. Not a Republican majority.

Mr. COBLE. Mr. Franks asked for this. Let me yield to the gentleman from Arizona for the remainder of my 5 minutes.

Mr. FRANKS. Well, I thank the gentleman. And I don't want to carry this much further, but there is no question that the past Administration has responsibility in these challenges. I was one of the members of my own party that did vote against some of the so-called solutions to those problems.

But let me just say to you whatever the Bush administration did in terms of debt, the Obama administration has surpassed them profoundly. This Administration has done for spending what Stonehenge did for rocks. And let me suggest to you that when I mentioned that 160 billion—$166 billion of spending deficit in 1 day was higher than the last totally controlled—Republican-controlled deficit for 1 year, that is a matter of fact.

But in any case we just have to realize that sometimes we got to get back to 101 economics and realize that no matter how much money we have in our pockets, if there is nothing being produced in this country in terms of goods and services, it won't work. And everything I see coming out of this Democrat majority has put a burden on the jobs market and has weighed down the economy in ways that I will suggest to you that the future will manifest in fairly dramatic terms. It already has done that.

And I guess I would have to go ahead and take one last thought here, Mr. Chairman. My friend says that we shouldn't politicize the defense of this country. I couldn't agree with him more. And yet the last two defense authorization bills passed by this Congress has had major social engineering forced on the backs of our soldiers by this majority. So I just would suggest that that is something that probably he probably should have left off.

And with that, I will yield back.

Mr. CONYERS. Could the gentleman yield?

Mr. FRANKS. I would be glad to yield to the gentleman.

Mr. CONYERS. I just wondered what were those social engineering projects that were forced upon the——

Mr. FRANKS. Well, this is the hate crimes legislation, the Don't Ask, Don't Tell. That should be legislation that should be voted separately, not when we are trying to fund the people out there pouring their blood out on some battlefield for all of us.

Mr. WATT. Gentleman yield?

Mr. COBLE. Well, it is my time. I will yield very briefly, Mel, but I think the Chairman wants to get on with the witness, but I will yield.

Mr. WATT. Well, we didn't——

Mr. COHEN. No, I think we are all enjoying this.

Mr. WATT. We are just trying to finish it on a very positive note, my friend from North Carolina. And just to let him know that people who don't ask and don't tell of all persuasions shed their blood, too. So, you know, that is not social engineering. That is personal characteristics of people, and all of them are Americans just like we are.

Mr. FRANKS. Mr. Chairman, could I move that we just put the witnesses' statement in the record and continue this debate up here? That might be a quick—okay. I see that we got the Chairman here. I think we got a consensus here at last.

Mr. COBLE. Let me reclaim and yield back.

Mr. COHEN. Mr. Coble, normally you are much more temperate, but look what you have got us into.

Mr. COBLE. Hold me harmless for that, Mr. Chairman.

Mr. COHEN. You are. You have got many credits.

Mr. Scott of Virginia?

Mr. SCOTT. Thank you, Mr. Chairman.

Mr. Chairman, I am a Member of the Budget Committee, and when I hear the other side talking about fiscal responsibility, I would first like to point out that there was—everybody knows we have a big deficit, and there was a suggestion in the Senate that we have a budget commission to make the tough choices that nobody likes to make when you are dealing with the budget. If you got a deficit, you have to raise taxes or cut spending, and nobody wants to do that.

And we had a suggestion to have a budget commission to make the tough choices. It is a bipartisan idea in the Senate. When the President endorsed it, it came out to vote and was defeated in the Senate, because at least seven Republicans, co-sponsors of the bill, voted no. So this, you know, that is how serious this debate is.

Now, the fact of the matter is we have a big budget deficit, but we would like to be precise as to what the criticism is. The criticism is that the policies we have now were instituted during the Bush administration. We have a deficit because of Republican policies, and Democrats now in control haven't cleaned it up fast enough. Okay.

We haven't cleaned it up fast enough, because we made a deliberate choice that we would deal with jobs first. We didn't want to increase taxes or cut spending in the middle of the worst recession since the Great Depression. So we will take the criticism. We haven't cleaned up the mess as quickly as we should have, because we had another mess that we were dealing with.

Now, the gentleman from North Carolina, Mr. Watt, talked about the 1993 vote where we turned around and went on a course of fiscal responsibility that included PAYGO, and we fixed the budget. We went on a trajectory that got us to the point where in 2001 we had a surplus, a projected surplus sufficient to pay off the national debt held by the public by 2008. If we hadn't messed up, we would have paid off the debt held by the public.

And to show you what was going on, Chairman Greenspan in answering questions had to answer questions like what will happen when we pay off the national debt? What will happen to interest rates? What is going to happen to the bond market when we pay

off the national debt after the first tax cut? That was the last time you heard anybody talking about paying off the national debt.

Now, the gentleman from Arizona says—or somebody over there said, "But wait. We were in control after 1995 of the Congress, so we deserve some credit." Now, that is a bold statement when you look at the facts.

In 1995 when they came in, they passed a budget. It had reckless fiscal policies in it, and President Clinton promptly vetoed it and would not sign the bill. He let the government get shut down rather than sign those irresponsible budgets. And as a result of his vetoes and enough Democrats left over to sustain the vetoes, we went on course to be paying off the national debt. We would have finished paying off the national debt by 2008.

For someone to take credit for being there when they tried to dismantle the policies that were in effect and institute policies that would take us in the direction, and they want some credit, that is a bold idea. And do you want to know what would have happened if President Clinton had signed it? We found out in 2001. President Bush signed it, and we promptly went right into the ditch with the worst fiscal policy, the worst stock market, the worst job performance since the Great Depression, for 8 consecutive years.

Now, we are going to fix the problem. In 1993 when the bills passed, we passed that great budget without a single Republican vote in the House, not a single Republican vote in the Senate. And as a matter of fact, when Marjorie Margolies-Mezvinsky cast the 218th vote to pass the bill, the Republicans started chanting, "Bye-bye, Marjorie," and they used that vote to defeat her in an upcoming election.

We are going to fix the job situation. We are going in the right direction. We haven't gotten where we need to be, but we are going in the right direction. We passed the jobs bill without a single Republican vote in the House or the Senate.

And then we are going to attack the deficit, and we don't expect any support from the Republicans. We are going to just go and fix it over their objections. But to be lectured by somebody about fiscal responsibility with that history is a bit much for somebody on the Budget Committee to take.

Now, one of the things that we passed—again, without any Republican votes—was medical health care reform. And talking about medical bankruptcies because of health care reform when it is fully implemented, there will be caps on how much money the insurance companies can make you pay out of pocket. And so when you reach the cap, all the rest is on the insurance companies. And this will significantly reduce the need for bankruptcy because of health care expenses.

The gentleman from Georgia talked about people going bankrupt with medical expenses. Most of them have insurance. There are the co-pays and deductibles that killed them. And so with the limit on out-of-pocket expenses and no caps on insurance companies having a cap on how much they are going to spend a year or how much they are going to spend on a lifetime, people will be able to have their health care needs addressed without having to resort to bankruptcy. It will take a couple of years to fully implement it, but that

is what we did—again, without a single Republican vote on final passage of that bill.

Thank you, Mr. Chairman. We just thought we would get all the facts on the table so that we can talk about fiscal responsibility and health care.

Mr. COHEN. Ms. Chu?

Ms. CHU. Mr. Chair, I would like to yield my time to the distinguished Chair of our entire Judiciary Committee, Mr. Conyers.

Mr. CONYERS. Thank you very much.

I want to hear the witnesses, believe it or not. But this is a pretty interesting conversation going on, you have to admit, because there is really wonderful recall on the part of Bobby Scott and Mel Watt about the history of how we got to where we are.

But Trent Franks happens to be a friend of mine. The fact that we have differences in some approaches doesn't bother me a bit. But for a person who has had so many surgeries in his own personal life, it is difficult for me to understand why he would resist health care reform with such fervor.

Those surgeries were probably pretty expensive, and we have 50 million people in America that don't have a dime's worth of insurance right now. And for him to say and to talk in a derogatory manner about health care reform being Obamacare—I never mind him using that phrase, because it is to Obama's credit that he got this bill through.

It took a year-and-a-half to finally get through a very modest set of measures that brought health care to 31 million people that weren't qualified. It ended pre-existing conditions as an excuse to kick people off of insurance. And so, as modest as it was, he called it socialized approaches. That is a veiled way of saying it is socialized medicine.

Mr. FRANKS. Correct.

Mr. CONYERS. And the whole idea strikes me as inappropriate for someone who, not by choice, was required to go through so much medical attention himself. It really leaves us something to talk about, and I would be pleased to yield to the gentleman, if he would like me to.

Mr. FRANKS. Well, Mr. Chairman, I will be really brief, because I appreciate your intent and your heart, and I know that our disagreement here is based not on any sort of humanitarian foundation, but on a genuine conviction that the strategies to pursue the desired end are different.

I truly believe—and I really didn't mean to get personalized in this situation—that if I had been born under a socialized medicine era, that I simply would not have gotten the level of care that I got, because if there is anything that one might say—I mean, history has borne out. I think Bastiat said it best. He said, "Government is that great fiction through which everyone endeavors to live at the expense of everyone else."

And in the final analysis, over time nothing has dragged more people—poor people—out of poverty, nothing has given more children born with deformities like myself or others, nothing has done more for those who needed it—needed help—more effectively over a sustained period of time than free people pursuing their dreams, whether it is as a doctor or whatever it might be, so they are able

to provide these kinds of services in the most effective, efficient manner.

And somehow we just think that it all appears magically by simply saying, "Well, the government will pay for it." We don't realize that when the government gets in the middle of all this, it actually retards the situation, actually hurts the situation.

If I had been born in the Soviet Union—it wasn't that people aren't smart over there. It is that their system's no damn good. And unfortunately, if I had been born there, I wouldn't be able to speak here at this Committee. And so I first of all thank God for the chance to do that, but I will say to you that I am convinced with all of my heart that my motivation here for free enterprise is so people like me can be born and have the kind of care that they need, and I don't think socialized medicine will deliver. It never has.

Mr. CONYERS. Well, thank you very much for that statement, because I know it is heartfelt. Trent, in the Soviet Union they have a communist system of government, not a socialist system of government. They are two quite different things.

Mr. FRANKS. [Off mike.]

Mr. CONYERS. Of course, there is a difference. And you still persist in describing the health care reform bill that was passed by a majority of the House and the Senate as a socialist system. What is socialized medicine about allowing more people on Medicaid by raising the ceiling eligibility? What is socialist about that?

Mr. FRANKS. [Off mike.]

Mr. CONYERS. Of course, I do.

Mr. FRANKS. Mr. Chairman, the difference in—you know, I guess socialism is sort of socialism on a retail basis, and communism is socialism on wholesale basis. But the reality is that when you put government in control, where government is in control of the mechanisms for delivery, you inevitably create a socialist environment. And it just doesn't work.

I mean, it is true that free enterprise is sometimes the unequal distribution of wealth. That is true. But socialism is always the equal distribution, ultimately, of poverty. It always ends in that direction. And I don't think we realize that unless the system incents productivity, in the final analysis there is nothing there for anyone.

And it is hard to express it in terms that sound, you know, humanitarian, but that is what I want to do. I think, for instance, I think all of us have a right to run for office here. But not all of us have a right to call on the government to make sure that we win. All of us have a right to have access to our courts, but not all of us have a right to say to the government, "You must make sure that I win my case."

Equal opportunity and equal outcomes are different. And I just think that if there is anything that has taught us it is, I mean, the highway of history is littered with the wreckage of socialism. And I don't know why we have to continue to learn this lesson. And yes, I do think Obamacare moves us precipitously and dramatically in that direction.

And so with that, I don't want to—you know, I state all of this respectfully to the Chairman and yield back.

Mr. CONYERS. Of course, Trent. Thank you very much.

Well, perhaps you may be right. Let me ask you. Who runs Social Security in this country? Who runs Social Security in this country?

Mr. FRANKS. Mr. Chairman, I think you make a good example. I think if we had a long time ago created a system where it said to people, "You must put a certain amount of your money into the mechanism of your choice," and we require that as a referee, we could have done that. But instead, government took it over, and now it is going to hell in a hand basket. So you make my point for me.

Mr. CONYERS. I see. Okay. Let me ask you this. Who runs Medicare in this country?

Mr. FRANKS. Well, I just would repeat my last statement.

Mr. CONYERS. All right. Then finally, Mr. Chairman, my friend Trent said that the majority of people in this country do not like the health care reform bill that was passed. And I am passing over to you a article—I think this is from the New York Times.

Mr. FRANKS. Where is this from?

Mr. CONYERS. Associated Press—in which it says, "Support for health care bill hits new high. More now support plan than oppose it." And I would pass it to my dear friend for his scrutiny and further discussion on it at another time.

Mr. FRANKS. Well, Mr. Chairman, I would just leave you with this. Not that the poll should be our deciding conclusion here, but the ones I have seen show in excess of 50 percent of the American people want to fully repeal the plan. So, and——

Mr. CONYERS. Do you have any citation for that, sir?

Mr. FRANKS. Could we try to find that for you?

Mr. CONYERS. I would like you to.

Mr. FRANKS. I will try to do that. I think I saw it just recently.

Mr. CONYERS. All right. Thank you.

Mr. FRANKS. Thank you.

Mr. CONYERS. And I want to thank the Chairman for his indulgence.

Mr. COHEN. I want to thank everybody for their input. It has been quite enlightening. I am a little confused, though, because Mr. Franks, who I respect, and I suspect knows a lot about socialism and communism, said communism is wholesale and socialism is retail. And my mother always told me to buy wholesale. So, you know, but I am confused.

And I would like to conclude this, if I could. It is my prerogative as Chairman to quote the former speechwriter of President George Bush, David Frum, who said on his Web site that the Republican Party's decision to uniformly oppose health care reform backfired. "We went for all the marbles. We ended with none. It was the Republican Party that made the big mistake," he argued, "by losing its grand bet that uniform opposition to Obamacare could prevent the measure from becoming law."

He said it is hard to exaggerate the magnitude of the disaster. He wrote while Republicans may win a short-term benefit, add more seats in Congress in November, he argued, "they will get little compensation for the enactment of a liberal—little compensation for the enactment of a liberal policy objective that could last generations and will be difficult, if not impossible, to repeal."

So we will see if Mr. Frum is correct.

With that said, I would like to ask unanimous consent to include in the record an article in the *Yale Journal of Health Policy Law and Ethics* titled "Managing Medical Bills on the Brink of Bankruptcy." Without objection, it will be done.

[The information referred to follows:]

ARTICLES

Managing Medical Bills on the Brink of Bankruptcy

Melissa B. Jacoby & Mirya Holman*

I. INTRODUCTION **240**
II. BACKGROUND AND METHODOLOGY **244**
A. MANAGING OUT-OF-POCKET LIABILITY 244
1. IN GENERAL 244
2. MEASURING MEDICAL BURDENS OF BANKRUPTCY FILERS 257
B. DATA FOR THE CURRENT STUDY 262
III. ANALYSIS AND FINDINGS **265**
IV. DISCUSSION **286**
V. CONCLUSION **288**

This Article is forthcoming in the Summer issue of the Yale Journal of Health Policy, Law, and Ethics, and may be cited as 10 YALE J. HEALTH POL'Y L. & ETHICS 239 (2010).

* Jacoby is the George R. Ward Professor of Law at the University of North Carolina at Chapel Hill School of Law and Visiting Professor of Law at Brooklyn Law School (2009-2010). Holman is an Assistant Professor of Political Science at Florida Atlantic University. For helpful comments on prior drafts, thanks to Scott Baker, Frederic Bloom, Al Brophy, Elizabeth Gibson, Mark Hall, Jim Hawkins, Jill Horwitz, Edward Janger, Timothy Jost, Joan Krause, Kimberly Krawiec, Robert Lawless, Bill Marshall, Christopher Robertson, Mark Rukavina, Richard Saver, Sidney Watson, and those who offered feedback at workshops, panel discussions, and colloquia at American University Washington College of Law, Brooklyn Law School, Duke University Law School, Georgia State College of Law, UNC School of Law, and the Petrie-Flom Center at Harvard Law School. Thanks to UNC for financial support of this project, to Tram Rattanavong, John Fitzpatrick, Louis Massard, Jabeen Ahmad, and Rachel Lerner for research assistance, and to Nick Sexton, Julie Kimbrough, and Dean Smith for library assistance. This paper analyzes data from the 2007 Consumer Bankruptcy Project ("2007 CBP"). The principal investigators of the 2007 CBP are David Himmelstein, Melissa Jacoby, Robert Lawless, Angela Littwin, Katherine Porter, John Pottow, Teresa Sullivan, Deborah Thorne, Elizabeth Warren, and Steffie Woolhandler. The 2007 CBP received external funding from the Robert Wood Johnson Foundation, the AARP, and the Federal Deposit Insurance Corporation (FDIC). None of the funders or other principal investigators is responsible for the analysis reported here.

> Medical men who frequently go to law to recover fees generally lose more in the end than they gain; not only because such attempts to recover often prove fruitless, but because they excite prejudice and make influential enemies.
>
> DANIEL WEBSTER CATHELL, THE PHYSICIAN HIMSELF FROM GRADUATION TO OLD AGE 292 (1925).

I. INTRODUCTION

In the vast majority of health care interactions, patients in the United States–regardless of their insurance status–bear some direct financial liability to medical providers.[1] Whether they are not-for-profit hospitals or for-profit small businesses, health care providers cannot be indifferent to the collection of these obligations. Consultants in medical practice management have developed and marketed extensive advice for structuring all aspects of providers' interactions with patients to mimic commercial transactions in other retail service contexts.[2] This advice, if successful, shields providers from the public scrutiny of after-the-fact debt collection through lawsuits and liens.[3]

Medical practice management affects the study of the financial burden imposed by health care. In recent years, lawmakers and scholars have debated the role of medical problems in fueling personal bankruptcy filings. Some scholars measure medical-related bankruptcy using survey techniques. Skeptics of survey-based findings often cite studies of bankruptcy court records that yield more conservative estimates. Court record studies look for evidence of claims by creditors with medical identities in the documents that bankruptcy filers submit to the court.

A clash over these methods arose directly prior to the passage of the

---

1. *See infra* Part II.A.

2. *See, e.g.*, Anna Wilde Matthews, *Beyond Co-Pay: Surprise Bills at the Doctor's; To Ensure They Get Paid, Doctors Seek Entire Bill for Patient Share Upfront*, WALL ST. J., Aug. 5, 2009, at D1 (citing a doctor reporting that office staff had to train patients to see doctor visits like a trip to Wahmart—"pay before leaving").

3. For scrutiny of that debt collection, see, for example, Mark A. Hall & Carl E. Schneider, *Patients as Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 MICH. L. REV. 643 (2007); George A. Nation, III, *Obscene Contracts: The Doctrine of Unconscionability and Hospital Billing of the Uninsured*, 94 KY. L. J. 101 (2005).

Bankruptcy Abuse Prevention and Consumer Protection Act of 2005.[4] This bill was the most significant set of amendments to the Bankruptcy Code in a generation and substantially restricted debt relief for individual filers. Lawmakers who opposed the bankruptcy bill cited a 2005 study by Himmelstein, Thorne, Warren, and Woolhandler finding that approximately half of bankruptcies were medical-related.[5] Supporters of the bankruptcy bill countered with a court record analysis conducted within the Department of Justice (DOJ). According to the DOJ analysis, over half of the sample (54%) had no medical debt at all, the average medical debt among those with any such debt was under $5,000, and medical debt comprised only 5.5% of the total unsecured debt of the sample.[6] More recently, debates about health care finance intensified public interest in the financial impact of medical bills and these methodological disputes. In the summer of 2009, Himmelstein et al. reported that 62% of personal bankruptcies could be construed as medical-related.[7] President Obama used medical bankruptcy rates as a rationale for health care reform.[8] Lawmakers held hearings on whether the current health care system is bankrupting American families. At one such hearing in July 2009, Representative John Conyers cited the

4. Bankruptcy Abuse Prevention and Consumer Protection Act of 2005, Pub. L. No. 109-8, 119 Stat. 23 (2005).

5. *See infra* Part II.A.2.

6. *See infra* p. 265, tbl.1.

7. David U. Himmelstein, Deborah Thorne, Elizabeth Warren & Steffie Woolhandler, *Medical Bankruptcy in the United States, 2007: Results of a National Study*, 122 AM. J. MED. 741, 742 (2009).

8. President Obama cited the Himmelstein study during his campaign and has continued to reference the connection between medical bills and bankruptcy in statements to Congress. *See* BARACK OBAMA AND JOE BIDEN'S PLAN TO LOWER HEALTH CARE COSTS AND ENSURE AFFORDABLE, ACCESSIBLE HEALTH COVERAGE FOR ALL 1, 1 (2008), http://www.barackobama.com/pdf/issues/HealthCareFullPlan.pdf ("Over half of all personal bankruptcies today are caused by medical bills."). In an address to a joint session of Congress in early 2009, the President stated that "the crushing cost of health care . . . is a cost that now causes a bankruptcy in America every thirty seconds." President Barack Obama, Address to Joint Session of Congress (Feb. 24, 2009), *available at* http://www.whitehouse.gov/the_press_office/remarks-of-president-barack-obama-address-to-joint-session-of-congress. "In a letter to Democratic Senate leaders . . . the President said: 'Health-care reform is not a luxury. . . . [S]piraling premiums and out-of-pocket expenses are pushing [families] into bankruptcy and forcing them to go without the checkups and prescriptions they need.'" Catherine Arnst, *Study Links Medical Costs and Personal Bankruptcy*, BLOOMBERG BUSINESSWEEK, June 4, 2009, http://www.businessweek.com/bwdaily/dnflash/content/jun2009/db2009064_666715.htm.

Himmelstein study as evidence that health care reform was urgently needed.[9] But a scholar from the American Enterprise Institute countered by citing the earlier DOJ court record analysis and its more modest assessment of the role of medical debt in bankruptcy.[10]

Here, we provide the first attempt to reconcile these competing methods of measuring medical burden, applying both the survey method and court record method to the same set of filers in a single dataset. Our dataset, the 2007 Consumer Bankruptcy Project ("2007 CBP"), is a nationally representative sample of people who filed for bankruptcy in early 2007. This dataset consists of hundreds of variables from court records, questionnaires, and telephone interviews. It was compiled by professors of law, medicine, and sociology at seven major research universities, including one of the authors of this Article.

The court record medical debt in our sample is patterned very consistently with the earlier DOJ sample. Someone who used the DOJ analysis to suggest that medical bills were not a problem in bankruptcy presumably would be nearly as happy to cite the court record analysis of our dataset.

However, when we compare the court record method and survey method as applied to the same dataset, court records routinely reflect smaller or even zero medical obligations for filers who report out-of-pocket expenses on the questionnaire. Indeed, one out of four respondents who explicitly reported medical bills as a reason for filing for bankruptcy has court records with zero identifiable medical debt.

After exploring several theories for these discrepancies, we observe that the deviations are quite consistent with filers' medical bill management. In other words, due to credit use, the court record method is incapable of capturing some of the most significant medical obligations incurred before bankruptcy. For example, respondents who reported significant out-of-pocket expenses, but had little or no detectable medical debt in their court records, reported credit card and mortgage use for medical bills at significantly higher rates than other respondents.[11] Respondents who specifically cited medical bills as a reason for filing for bankruptcy mortgaged their homes to pay medical bills at *nearly four*

9. *See Medical Debt: Is Our Healthcare System Bankrupting Americans: Hearing Before the Subcomm. on Commercial and Administrative Law of the H. Comm. on the Judiciary*, 111th Cong. 4 (July 28, 2009) (opening statement of Rep. John Conyers, Jr.), *available at* http://judiciary.house.gov/hearings/pdf/Conyers090728.pdf.

10. *See id.* at 10 (written testimony of Aparna Mathur, Research Fellow, American Enterprise Institute), *available at* http://judiciary.house.gov/hearings/pdf/Mathur090728.pdf.

11. *See infra* p. 276, fig.4.

times the frequency of other filers.[12] They also were more than a third more likely than other filers to use credit cards for medical bills.[13] These mortgages and credit card bills are invisible in the court record method because they bear no sign of medical identity. Thus, the court record method, by itself, produces an estimate of medical burden that is not merely more conservative across the board, but skewed.

The distortion in the court record method does not seem to apply to all demographic groups uniformly, probably due to factors we cannot directly measure, such as access to credit and access to health care. Thus, interesting patterns emerge when we disaggregate our national sample on the basis of age, race, sex, and housing tenure. Court records make some filers appear as if they had incurred distinctively high medical debt because they were less likely to use credit cards or mortgages for medical bills. For similar reasons, other groups of filers have quite similar medical debts in the court records even though they incurred very different amounts of medical obligation prior to filing. Again, significant variations in medical debt management alter the picture the court records provide.

The findings reveal the problems with relying exclusively on court records to measure the financial impact of medical care. They also provide another perspective on the financial end of medical practice with which this article began. As previously noted, non-legal writings advise how medical providers should manage the risk of transacting with patients, in part because these writers have long feared that patients will put doctors at the bottom of the priority list of bills to pay.[14] The respondents in the current study often were facing financial difficulties when they sought medical care.[15] Yet, by the time they filed for bankruptcy, respondents had considerably reduced providers' direct financial exposure. This suggests that even patients with modest incomes and high debt-to-income ratios feel a sense of responsibility to their doctors. Alternatively, they are responding to providers' encouragements to reduce their direct liability.

---

12. *See infra* p. 274, fig.3.

13. *Id.*

14. *See, e.g.*, DANIEL WEBSTER CATHELL, THE PHYSICIAN HIMSELF FROM GRADUATION TO OLD AGE 292 (1925). *See also* sources cited *infra* Part IV.

15. In telephone interviews with a large subset of respondents in our sample, 44% reported that they had seriously struggled financially for more than two years before filing for bankruptcy. An additional 27% reported serious struggling for more than one year. We do not have this information for all respondents in the sample, but the telephone survey subsample is not significantly different from the whole regarding variables such as filing status, chapter, total assets, total debts, priority debts, monthly income, and home value. *See infra* text accompanying note 100.

This Article proceeds with the following Parts. Part II.A offers background on out-of-pocket medical bills and medical practice management advice. It then contextualizes our study by reviewing the methodological and political dispute over measuring medical burden among bankruptcy filers. Part II.B describes our dataset, giving special attention to the new questions and variables that enabled this study. Part III reports our findings. Part IV highlights some implications of our study for understanding the burden of health care spending on families and medical practice management.

II. BACKGROUND AND METHODOLOGY

A. Managing Out-of-Pocket Liability

1. In General

For many reasons, today's health care finance system expressly imposes cost-sharing and direct patient liability on patients who are covered by health insurance.[16] According to The Coker Group, a health care industry consultant firm, 90% of patients owe money directly at the time of service.[17] Furthermore,

16. *See generally* PAUL B. GINSBURG, ROBERT WOOD JOHNSON FOUND., HIGH AND RISING HEALTH CARE COSTS: DEMYSTIFYING U.S. HEALTH CARE SPENDING 19 (2008), *available at* http://www.rwjf.org/files/research/101508.policysynthesis.costdrivers.rpt.pdf (discussing consumer financial exposure as a method of controlling health care spending on low-value new technologies, assuming consumers have sufficient information); JONATHAN GRUBER, KAISER FAM. FOUND., THE ROLE OF CONSUMER COPAYMENTS FOR HEALTH CARE: LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT AND BEYOND 1 (2006) (describing cost-sharing and reporting impact on utilization and health outcomes); MILLIMAN, 2008 MILLIMAN MEDICAL INDEX 9 (2008) (of the "$15,609 total medical cost for a family of four under a PPO . . . the employee pays about $6,167," $2,675 of which is paid in cost-sharing at time of service); McKinsey & Company, *Why Americans Pay More for Health Care*, MCKINSEY Q., Dec. 2008, at 9 (noting that the "average" health care consumer pays 12% of the total cost directly out-of-pocket, in addition to 25% of the premium cost); Kaiser Fam. Found., *Snapshots: Health Care Costs: Distribution of Out-of-Pocket Spending for Health Care Services*, May 2006, http://www.kff.org/insurance/snapshot/chcm050206oth.cfm (noting that the average share paid out-of-pocket by non-elderly people with private insurance and any health spending in 2003 was 34%); Ann Kjos, New Prospects for Payment Card Application in Health Care, Federal Reserve Bank Philadelphia Payment Cards Center Discussion Paper 1 (Nov. 2008), *available at* http://www.phil.frb.org/payment-cards-center/publications/discussion-papers/2008/ D2008NovemberHealthCareCardApplication.pdf ("[O]ut-of-pocket expenditures, which consumers pay directly to medical service providers, are not insignificant and are expected to grow from the current level of about $269 billion.").

17. THE COKER GROUP, MAXIMIZING BILLING AND COLLECTIONS IN THE MEDICAL PRACTICE 41

obligations to be collected directly from patients represent, on average, 15-20% of a medical provider's receivables.[18] At least prior to the enactment of health care finance reform, the Centers for Medicare and Medicaid Services predicted continued increases in patient out-of-pocket payments.[19] In an analysis of a recent Medical Expenditure Panel Survey, the authors reported that a fifth of privately insured non-elderly families had out-of-pocket obligations exceeding 5% of their incomes.[20]

As an interesting sign of the times regarding direct medical obligations, a few years ago a bank started issuing a "Healthcare Visa Gift Card."[21] The website for the Visa card lists a variety of occasions for which such a gift might be appropriate.[22] Although new card orders are no longer being taken, the vendor of the cards called them a "hot new Christmas gift."[23] Gift-givers could get the card in amounts ranging from $25 to $5,000, and using the card would be fee-free for the recipient for eight months, after which the recipient would pay a monthly maintenance fee of $1.50.[24] Existing cards may be used for health club membership and totally elective surgery as well as for dental care and co-pays at doctors' offices.[25]

Certainly many people with modest out-of-pocket obligations or higher

(2007).

18. Mitch Patridge & Doug Barry, *Compassionate Patient Financing Can Cure a Hospital's Financial Ills*, 32 J. HEALTH CARE FIN. 168, 171 (2006); Richard Haugh, *Financial Aid: From Direct Debits to New Loans, Patients Get New Ways To Pay Off Hospital Bills*, HOSP. & HEALTH NETWORKS, Nov. 2006, at 18. Patridge and Barry note that these receivables represent only 2-5% of net revenue due to insufficient collection practices. *See* Patridge & Barry, *supra*.

19. *See* Christopher J. Truffer et al., *Health Spending Projections Through 2019: The Recession's Impact Continues*, 29 HEALTH AFF. 522, 526 (2010) (noting a 4.8% average annual percentage growth for out-of-pocket payments over the projection period 2009-2019).

20. *See* GRUBER, *supra* note 16, at 11. This excludes insurance premiums. *See, e.g.*, DIDEM BERNARD & JESSICA BANTHIN, MED. EXPENDITURE PANEL SURV., FAMILY-LEVEL EXPENDITURES ON HEALTH CARE AND INSURANCE PREMIUMS AMONG THE U.S. NONELDERLY POPULATION, 2004, 14, 15 (2007) (defining terms used in MEPS surveys).

21. *See* Givewell.com, Where To Use It, http://www.givewell.com/where-to-use (last visited Apr. 1, 2010) ("Promote happiness, give a Healthcare Visa Gift Card").

22. *See* Givewell.com, Occasions To Give, http://www.givewell.com/occasions-to-give (last visited Apr. 1, 2010).

23. *Medical Gift Cards Trendy*, HEALTH CARE COLLECTOR (Aspen Publishers, New York, N.Y.), Feb. 2008, at 11.

24. *See* Givewell.com, How It Works, http://www.givewell.com/how-it-works/ (last visited April 2, 2010).

25. *Id.*

incomes pay immediately and without serious consequence. But contemporary studies continue to report that cost-sharing results in delinquent medical debt with some prevalence,[26] even for routine care.[27] Nationally representative studies estimate that tens of millions of households have accrued medical debt and/or have problems paying medical bills.[28] Concerns about medical debt are longstanding and have transcended the evolution of health care finance.[29]

---

26. Many published papers and unpublished online policy briefs make this point. For recent examples, see ANDREW COHEN & CAROL PRYOR, IN DEBT BUT NOT INDIFFERENT: CHAPTER 58 AND THE ACCESS PROJECT'S MEDICAL DEBT RESOLUTION PROGRAM (2008), *available at* http://www.accessproject.org/adobe/InDebtButNotIndifferent.pdf; SIDNEY D. WATSON ET AL., LIVING IN THE RED: MEDICAL DEBT AND HOUSING SECURITY IN MISSOURI (2007), *available at* http://www.accessproject.org/adobe/living_in_the_red.pdf; Cathy Schoen et al., *How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007*, 27 HEALTH AFF. w298, w304 tbl.4 (2008) (reporting that increasingly significant proportions of insured population pay out-of-pocket).

27. *See, e.g.*, PAUL FRONSTIN & SARA R. COLLINS, EMPLOYEE BENEFIT RESEARCH INST., FINDINGS FROM THE 2007 EBRI/COMMONWEALTH FUND CONSUMERISM IN HEALTH SURVEY 9-10 (2008); WILLIAM LOTTERO ET AL., LOSING GROUND: ERODING HEALTH INSURANCE COVERAGE LEAVES KANSAS FARMERS WITH MEDICAL DEBT 10 (2006), *available at* http://www.accessproject.org/adobe/losing_ground.pdf (nearly 60% with medical debt reported owing money for routine care); Jessica S. Banthin, Peter Cunningham & Didem M. Bernard, *Financial Burden of Health Care, 2001-2004*, 27 HEALTH AFF. 188 (2008) (studying out-of-pocket obligations plus premium costs across population); PETER J. CUNNINGHAM, CAROLYN MILLER & ALWYN CASSIL, LIVING ON THE EDGE: HEALTH CARE EXPENSES STRAIN FAMILY BUDGETS 3 (Ctr. for Studying Health Sys. Change, Res. Brief No. 10, 2008), *available at* http://www.hschange.com/CONTENT/1034/1034.pdf (explaining how trouble paying medical bills can result from non-catastrophic expenses).

28. In a Commonwealth Fund study, 72 million "working age" people and an additional 7 million over 65 had accrued medical debt and/or problems paying medical bills, an increase over earlier studies. *See* SARA R. COLLINS ET AL., LOSING GROUND: HOW THE LOSS OF ADEQUATE HEALTH INSURANCE IS BURDENING WORKING FAMILIES: FINDINGS FROM THE COMMONWEALTH FUND BIENNIAL HEALTH INSURANCE SURVEYS, 2001-2007, vii (Commonwealth Fund Issue Brief, 2008), *available at* http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2008/Aug/Losing-Ground--How-the-Loss-of-Adequate-Health-Insurance-Is-Burdening-Working-Families--8212-Finding.aspx; *see also* Schoen et al., *supra* note 26 (reporting 16% were contacted by debt collectors about medical bills). In another study, 57 million people in 2007 (14 million more than in 2003) were in households with trouble paying medical bills. PETER J. CUNNINGHAM, TRADE-OFFS GETTING TOUGHER: PROBLEMS PAYING MEDICAL BILLS INCREASE FOR U.S. FAMILIES 2003-2007, 1 (Center for Studying Health Sys. Change, Tracking Rep. No. 21, 2008), *available at* http://www.hschange.com/CONTENT/1017/1017.pdf.

29. *See, e.g.*, Jonathan Cohn, *This Won't Hurt a Bit: Health Care Reform for Dummies*, NEW REPUBLIC, Feb. 18, 2009, at 18 (reporting on the Committee on the Costs of Medical Care from the

Health policy researchers and patient advocates have articulated specific worries about how medical debt affects patients and their families. Prominent examples of such worries include the following: patients may self-ration medically necessary care and drugs;[30] medical providers may deny non-emergency care;[31] patients may self-ration important *non*-medical expenses;[32] providers or their designees may engage in harsh formal debt collection activity;[33] patients may experience adverse psychological consequences from fear about medical debt that in turn may aggravate health conditions;[34] certain demographic groups may be disproportionately impacted by cost-related or debt-related access problems;[35] and patients may experience pressures to convert

---

1930s and the concern that medical bills destabilize household finances); Editorial, *Most People Need No Aid To Pay the Doctor's Bill*, SATURDAY EVENING POST, Jan. 10, 1953, at 10, 12 (arguing that U.S. News story was an overreaction to data from academic study); *Special Report: Doctor Bills Pile Up: How Can Families Pay?*, U.S. NEWS & WORLD REP., Oct. 17, 1952, at 65-70 (reporting on academic study finding that one in five families had outstanding medical debt).

30. This point is frequently made. For a few recent entries to the literature, see, for example, PETER J. CUNNINGHAM & LAURIE E. FELLAND, FALLING BEHIND: AMERICANS' ACCESS TO MEDICAL CARE DETERIORATES, 2003-2007, 2 (Center for Studying Health Sys. Change, Tracking Rep. No. 19, 2008), *available at* http://www.hschange.com/CONTENT/993/993.pdf (noting cost was "most frequently cited—and growing—obstacle to care"); Cathy Schoen et al., *In Chronic Condition: Experiences of Patients with Complex Health Care Needs, in Eight Countries, 2008*, 28 HEALTH AFF. w1, w5 (2008) (discussing cost-related deterrence of treatment, particularly among U.S. patients); Robert W. Seifert & Mark Rukavina, *Bankruptcy Is the Tip of a Medical-Debt Iceberg*, 25 HEALTH AFF. w89, w90 (2006).

31. *See, e.g.*, CUNNINGHAM, *supra* note 28, at 3 ("In 2007, about 10 percent of people with medical bill problems reported being denied care by medical providers directly as a result of their medical bill problems.").

32. *See, e.g.*, Cunningham et al., *supra* note 27, at 4-5 (discussing families who are late on mortgages and cut down other expenses due to medical bill problems); *id.* at 8 (discussing choice between medical bills and keeping children housed and fed); Robert W. Seifert, *Home Sick: How Medical Debt Undermines Housing Security*, 51 ST. LOUIS U. L.J. 325 (2007).

33. *See generally* Melissa B. Jacoby & Elizabeth Warren, *Beyond Hospital Misbehavior: An Alternative Account of Medical-Related Financial Distress*, 100 NW. U. L. REV. 535 (2006) (documenting concerns of patient advocates).

34. *See, e.g.*, CAROL PRYOR, ANDREW COHEN & JEFFREY PROTTAS, THE ILLUSION OF COVERAGE 9 (2007), *available at* http://www.accessproject.org/adobe/the_illusion_of_courage.pdf; Wilhelmine Miller, Elizabeth Richardson Vidgor & Willard G. Manning, *Covering the Uninsured: What Is It Worth?*, HEALTH AFF. W4-157, W4-162 (Web Exclusive Mar. 2004) ("The social stigma and psychological stresses of medical indigency, health care debt, and bill collection efforts are themselves burdensome.").

35. *See, e.g.*, ELIZABETH M. PATCHIAS & JUDITH WAXMAN, WOMEN AND HEALTH COVERAGE:

medical debt into third-party credit that could substantially increase the size of those bills and other consequences.[36]

The world looks different from the perspective of the medical practice management field. As the following paragraphs will illustrate, writers in this field focus on protecting health care *providers*, rather than patients, from unpaid debt. While scholars from many disciplines continue to debate whether medical care should be treated as an ordinary commodity,[37] those on the front lines of practical

---

THE AFFORDABILITY GAP 5-6 (Commonwealth Fund Issue Brief, 2007), *available at* http://www.nwlc.org/pdf/NWLCCommonwealthHealthInsuranceIssueBrief2007.pdf (reporting on medical debt among people with health insurance).

36. *See, e.g.*, SARA COLLINS ET AL., THE COMMONWEALTH FUND, THE AFFORDABILITY CRISIS IN HEALTH CARE: FINDINGS FROM THE COMMONWEALTH FUND BIENNIAL HEALTH INSURANCE SURVEY 32 (2004), *available at* http://www.commonwealthfund.org/usr_doc/collins_biennial2003_723.pdf (one in five medical debtors had large credit card debt or home mortgage to pay medical bills); DEMOS & CTR. FOR RESPONSIBLE LEARNING, THE PLASTIC SAFETY NET: THE REALITY BEHIND DEBT IN AMERICA 56-57 (2005), *available at* http://www.demos.org/pubs/PSN_low.pdf (reporting that medical bills contributed to credit card debt for 29% of low and middle income households); NAT'L CONSUMER LAW CTR., UNHEALTHY PURSUITS: HOW THE SICK AND VULNERABLE ARE HARMED BY ABUSIVE MEDICAL COLLECTION TACTICS, 36 (2005), *available at* http://www.consumerlaw.org/news/content/medicaldebt.pdf (suggesting that providers have encouraged patients to take on high-cost credit for bills); CINDY ZELDIN & MARK RUKAVINA, BORROWING TO STAY HEALTHY: HOW CREDIT CARD DEBT IS RELATED TO MEDICAL EXPENSES (2007), *available at* http://www.demos.org/pubs/healthy web.pdf; Cunningham et al., *supra* note 27 (giving examples of credit card, mortgages, and personal loan use for medical bills); Brian Grow & Robert Berner, *Fresh Pain for the Uninsured: As Doctors and Hospitals Turn to GE, Citigroup, and Smaller Rivals To Finance Patient Care, the Sick Pay Much More*, BUS. WK., Dec. 3, 2007, at 34 (reporting on loan arranging for bills of patients who were unaware of the third-party arrangement); USA Today/Kaiser Family Foundation/Harvard School of Public Health, Health Care Costs Survey, Summary and Chartpack, Chart 3 (Aug. 2005), *available at* http://www.kff.org/newsmedia/upload/7371.pdf (reporting that 8% borrowed money or got second mortgages because of problems with paying medical bills). In a recent tracking survey, about one in ten respondents with problems paying medical bills reported that their providers suggested that they take out loans to meet their health care obligations. CUNNINGHAM, *supra* note 28. Two national publications recently cited Senator Grassley's concern that medical providers are "cozying up to banks, debt buyers, and credit card companies over patients' medical bills." Grow & Berner, *supra*, at 34 (quoting a statement that Senator Grassley provided to Business Week); *Overdose of Debt: Lenders Push Risky Credit for Everything from Cancer Care to Botox*, CONSUMER REPS., July 2008, at 14, 18 (reporting the same statement).

37. Philip E. Tetlock, *Coping with Trade-Offs: Psychological Constraints and Political Implications*, *in* ELEMENTS OF REASON: COGNITION, CHOICE, AND THE BOUNDS OF RATIONALITY 251 (Arthur Lupia et al. eds., 2000) ("Liberals view the buying and selling of conventional medical

advice to providers largely proceed from the assumption of commercial exchange.[38] For the most part, a report published by the American Medical Association strongly emphasizes this theme, reminding doctors, "It's your money–ask for it!"[39]

Medical practice management writings instruct providers on such matters as: how to get payments up front (including before services are rendered);[40] how to

services and, to some degree, legal services as suspect categories—people seem to be buying health, life, and justice—whereas conservatives are not bothered by such transactions."); Mark A. Hall & Carl E. Schneider, *The Professional Ethics of Billing and Collections*, 300 JAMA 1806 (2008); Pamela Hartzband & Jerome Groopman, *Money and the Changing Culture of Medicine*, 360 NEW ENG. J. MED. 101 (2009); Marc A. Rodwin, *Medical Commerce, Physician Entrepreneurialism, and Conflicts of Interest*, 16 CAMBRIDGE Q. HEALTHCARE ETHICS 387 (2007); Deborah A. Stone, *The Doctor as Businessman: The Changing Politics of a Cultural Icon*, 22 J. HEALTH POL. POL'Y & L. 533 (1997).

38. *See generally* Hall & Schneider, *supra* note 37 (discussing model generally used by health care providers).

39. Specifically, The Coker Group report advises:

> If, for some reason, the patient indicates an inability to make a payment, the staff member should call the billing manager . . . The manager should take the patient to a private room to discuss payment. The element of authority imposed by the billing or practice manager indicates that nonpayment is unacceptable. At the discretion of the manager, the patient may be allowed to leave without paying, but, preferably, with an agreed-upon plan for payment. In some cases, a fee should be charged if the patient is to be billed. . . . The long-range goal is to develop the understanding that arrangements for payments must be made in advance of the patient encounter. As with most matters related to credit and collection policy, it is essential to be consistent across the patient base. Consistent patterns of collection inform both the staff and the patients that direct patient payment is important. It's your money—ask for it!

THE COKER GROUP, *supra* note 17, at 42-43.

40. *See, e.g.*, Judy Capko, *Physicians Practice Pearls: You Earned It, Now Collect It*, PHYSICIANS PRAC., June 2007, *available at* http://www.physicianspractice.com/index/fuseaction/articles.details/articleID/1008.htm (recommending payments at time of service); Pamela Lewis Dolan, *Collecting the Patient Portion: Being Proactive, Early and Often*, AM. MED. NEWS, April 2, 2007, at 18 (citing health care consultant saying "'Everyone needs to sign on that we are going to collect co-pays at the time of service.'. . . The patient needs to be reminded over and over that this is the new system."); Kim LaFontana & Kim Williams, *Practice Management Lab: Finding Success with Self-Pay*, PHYSICIANS PRAC., July/Aug. 2006, *available at* http://www.physicianspractice.com/index/fuseaction/articles.details/ articleID/858.htm (referring to time of service as the "golden moment" for collecting payments from patients); Deborah Shapiro, *How To Address Patient Payments: Can't Pay . . . Won't Pay . . . Should Pay*, HEALTH CARE COLLECTOR (Aspen Publishers, New York, N.Y.), Mar. 2008, at 3 ("The best time to collect money from patients is before the service is rendered, or at least right after the service and before they walk out the door.").

financially screen patients;[41] when to terminate or embargo patients for nonpayment;[42] how to physically arrange a medical office or hospital to encourage payment;[43] what color envelopes should be used for medical bill collection letters;[44] and even the optimal physical posture a staff member should

41. For evidence of interest in financial screening of patients, see, for example, Emily Berry, *Taking a Financial History: Determining the Health of Your Patient's Credit Rating*, AM. MED. NEWS, Jan. 19, 2009, at 15; *Financial Triage: Innovative Ways That Hospitals Are Looking at Patient Finances*, BUS. WK., Nov. 20, 2008; Dave Hansen, *Giving Credit To Get What's Due: How Doctors Can Help Patients Pay the Bill*, AM. MED. NEWS, Jan. 21, 2008, at 15; *Overdose of Debt: Lenders Push Risky Credit for Everything from Cancer Care to Botox*, CONSUMER REPS., July 2008, at 14, 17 (reporting on hospitals' use of credit scores or credit reports, and Equifax's Payment Predictor system); *Maximizing Self-Pay Collections: Moving the Process Ahead*, HEALTH CARE COLLECTOR (Aspen Publishers, New York, N.Y.), Jan. 2009, at 10 (discussing how hospitals may wish to use credit scoring or reporting "to get a glimpse of the patient's financial situation"); Judy I. Veazie, *Point-of-Service Collections: When It's Too Late To Collect*, HEALTH CARE COLLECTOR (Aspen Publishers, New York, N.Y.), Feb. 2009, at 4, 5 (reporting the use of credit reports by providers to determine an approach for the self-pay portion of bills).

42. *See, e.g.*, ROBERT J. SOLOMON, THE PHYSICIAN MANAGER'S HANDBOOK: ESSENTIAL BUSINESS SKILLS FOR SUCCEEDING IN HEALTH CARE 107-08 (2d ed. 2008) (proposing a sample collection plan, providing suspension of future appointments for a patient who misses two successive co-payments until payment is satisfied); THE COKER GROUP, *supra* note 17, at 41, 57 (recommending the dismissal of a chronic non-paying patient from a medical practice, particularly if it seems that the patient is not really in financial hardship); Dolan, *supra* note 40, at 18 (paraphrasing Jeff Peters, CEO of Health Directions, a Chicago-based consulting firm, "[t]here's no crime in telling patients their balance must be paid or arrangements for payment be made before they get another appointment"); Shirley Grace, *Physician Beware: 'The Dog Ate My Checkbook,'* PHYSICIANS PRAC., Feb. 2009, *available at* http://www.physicianspractice.com/index/fuseaction/articles.details/articleID/1285.htm; Wayne J. Guglielmo, *When Patients Can't Pay: You'll Collect More of What You're Owed—and Enhance Loyalty—If You Have a Payment Plan*, MED. ECON., June 3, 2005, at 49. One author compared conditioning treatment on payment for prior service to conditioning a future movie rental on payment for a prior rental. Curt Mayse, *Front Desk as Profit Center*, PHYSICIANS PRAC., Apr. 2005, *available at* http://www.physicianspractice.com/index/fuseaction/articles.details/articleID/641.htm.

43. *See, e.g.*, Suz Redfearn, *Pay Up, Self-Payer: Getting the Most from Patients Who Pay Out-of-Pocket*, PHYSICIANS PRAC., Mar./Apr. 2002, *available at* http://www.physicianspractice.com/index/fuseaction/articles.details/articleID/293.htm (recommending that offices be set up to require patients to pass the collections desk on the way to the exit).

44. *See, e.g.*, *Ten Tips for Improving Collection Letters*, HEALTH CARE COLLECTOR (Aspen Publishers, New York, N.Y.), Mar. 2009, at 12 (recommending medical providers "[t]est pastel-colored envelopes that will stand out against other mail" and "the use of PS to emphasize. . . strongest points" relating to collection).

assume when attempting to collect from patients.[45] Sources recommend making a "game" out of billing for employees to maximize receipts[46] or motivating billing and collections employees with coffee cups, T-shirts, gift certificates, additional vacation days, or merit certificates.[47]

If doctors adhere to the advice with some success, they may be able to avert the need for formal and more public *ex post* debt collection efforts.[48] The practice management literature thus implicitly and explicitly encourages medical providers to shift the risk of patient default to third-party creditors: the common advice is, whenever possible, to "push the problem of nonpayment on to someone else."[49]

---

45. *Collecting Assertively Is an Acquired Skill: Confidence and Empathy Are Key*, HEALTH CARE COLLECTOR (Aspen Publishers, New York, N.Y.), Dec. 2007, at 7, 8 (recommending "good posture—no slouching" while collecting medical bills in person or on the phone).

46. Dolan, *supra* note 40.

47. THE COKER GROUP, *supra* note 17, at 38.

48. *See, e.g.*, Robert B. Avery et al., *An Overview of Consumer Data and Credit Reporting*, 89 FED. RES. BULL. 47, 67, 69 (2003) (using earlier data, estimating that medical bills accounted for 18.2% of court judgments on credit reports and 52.2% of collection agency actions).

49. Karen Caffarini, *Keeping Rubber Checks from Clogging Revenue Flow*, AM. MED. NEWS, Jan. 26, 2009, at 13; *see also* SOLOMON, *supra* note 42 (to make patient prioritize medical bills, "[r]emind the patient that he or she can use a credit card"); THE COKER GROUP, *supra* note 17, at 41; Jeffrey C. Levitt, *Transfer of Financial Risk and Alternative Financing Solutions*, 30 J. HEALTH CARE FIN. 21, 26 (2004) ("Likewise, medical providers would rather have another party take the financial exposure from patients rather than keep it on their own balance sheets. They are in the business of providing health care, not consumer financing."); Patridge & Barry, *supra* note 18, at 169-170 ("Whether in the form of credit cards, bank loans, or the more widely used electronic paper-free funding programs, it is critical that the hospital offer reasonable options to the patient without placing additional financial burdens on the hospital, such as carrying long-term payment plans."); Dolan, *supra* note 40 (reporting on consultant advising that medical practices should accept "all credit cards"); Mari Edlin, *A Fair Trade?: Make Payment Policies Fair and Legal*, PHYSICIANS PRAC., Nov. 2001, *available at* http://www.physicianspractice.com/index/fuseaction/articles.details/articleID/270.htm (citing practice manager saying: "We're not a bank. Take out a loan or charge it."); Guglielmo, *supra* note 42 (noting that experts suggest encouraging patients to put bill on credit card, rather than payment plan with provider, if patient is employed and not in particularly bad financial shape to "shift[ ] the credit burden . . . to the credit card company"); Pamela Moore, *Billing and Collections: Playing Hardball: Advice on Charging Interest and Late Fees on Past-Due Patient Accounts*, PHYSICIANS PRAC., Apr. 2008, *available at* http://www.physicianspractice.com/index/fuseaction/articles.details/articleID/1142.htm (encouraging providers to get patients to use credit cards for balances, or to encourage patients to borrow money from companies like CareCredit so "patient can work out his troubles with someone else"); Redfearn, *supra* note 43 (citing consultant recommending that providers "forge relationships

Credit cards facilitate the expectation in the health care marketplace that the patient will resolve the self-pay portion of a medical bill in a "retail business" fashion at the time of service.[50] Health care is analogized to hotels and car rental businesses when authors recommend that medical providers take credit card imprints before seeing or treating the patient.[51] Health industry consultants have extended such analogies by recommending "sales finance programs similar to those offered by appliance and auto dealers" for particularly large out-of-pocket medical expenditures.[52]

Providers and hospitals commonly take credit cards notwithstanding the servicing fees they must pay,[53] and a Federal Reserve Payment Card Center researcher has noted that doctors' offices more routinely include credit and debit card kiosks.[54] Not surprisingly, providers that have minimized ongoing patient receivables report a higher rate of identifying credit cards as an acceptable

---

with local banks that can quickly arrange to grant small loans to patients").

50. *See* Elizabeth S. Roop, *Debt Load: Building a Better Payment Plan (for Hospitals and their Patients)*, 82 HOSPITALS & HEALTH NETWORKS 46, 47 (June 2008) (reporting on how a medical facility "vigorously pursues upfront payments . . . [p]atients are given the opportunity to make a payment over the phone, which speeds collection for the hospital. A 20 percent discount is provided for up-front payments. . ."); Hansen, *supra* note 41; Kris Hundley, *As Medical Costs Grow, Creditors Get in the Game*, TAMPA BAY TIMES, Feb. 24, 2008, at 1D, *available at* 2008 WLNR 3634947 (referring to retail business model); Patrick Reilly, *Extracting Payment; Hospitals Try Collecting Before Patients Leave ER*, MOD. HEALTHCARE, Nov. 17, 2003, at 8; Veazie, *supra* note 41, at 4, 5 ("Point-of-service tools, including the acceptance of credit cards, are very important.").

51. Nick A. LeCuyer & Shubham Singhal, *Overhauling the US Health Care Payment System*, MCKINSEY Q., June 2007, at 6 (Web Exclusive), *available at* https://www.tipaaa.com/pdf/Overhauling%20the%20US%20Health%20Care%20Payment%20System-McKinsey%20Report.pdf(offering hotel and car rental analogy); Jayne Oliva, *Consumer Directed Health Care: Zeroing in on Physician Practices*, PHYSICIAN EXECUTIVE, May/Jun. 2005, at 66, 67 ("Today's self-service generation will impel health care to mirror the banking industry" in terms of service delivery formats.).

52. LeCuyer & Singhal, *supra* note 51, at 6.

53. *See, e.g.*, Jonathan G. Bethely, *Collecting Patients' Share Up-Front Getting Easier*, AM. MED. NEWS, Feb. 27, 2006, at 1; Edlin, *supra* note 49 (noting that majority of physician offices accept credit cards); Levitt, *supra* note 49 (reporting that most hospitals accept credit cards for payment). *But see Credit Cards and Medical Expenses: Combination Creates Dilemma for Patients, Providers*, RECEIVABLES REP., Apr. 2007, at 3 (citing a *Hospital Accounts Receivable Analysis* survey in which only 47% of hospitals reported offering their patients the option of paying bills with credit cards).

54. Kjos, *supra* note 16.

method of payment (92.2%).[55] Although the total volume of credit card expenditures for medical bills remains murky, estimates are in the tens of billions and, at least before the implementation of the Credit Card Accountability, Responsibility, and Disclosure (CARD) Act of 2009, were expected to multiply.[56]

Issues surrounding medical billing and payment are complicated further in the context of emergency hospital care. The Emergency Medical Treatment and Active Labor Act, enacted in 1986, requires that hospitals provide services to anyone in need of emergency care, regardless of ability to pay.[57] With emergency room revenue (or any revenue) being important to a hospital's bottom line,[58] much management literature advises on how to effectively seek payment while complying with federal law. Experts emphasize prompt screening, and one notes, "[T]he best-performing hospitals ensure that a high percentage of [emergency department] patients are financially screened prior to discharge."[59] After a patient is stabilized, emergency department billing and collections practice thus resembles those practices already discussed. For instance, one consultant advises against an emergency department layout with multiple exits, which would enable patients to leave without discussing payment.[60] This same source cites the benefits of incentive programs for collections staff and lists credit card equipment as among the "nuts and bolts" of the emergency room collections process.[61]

Credit products designed and offered specifically for patient management of out-of-pocket medical costs present another avenue for shifting risk away from providers.[62] Medical providers typically do not bear legal liability for being

55. Dolan, *supra* note 40.

56. According to secondary reporting on a Visa USA study, credit cards were used for about a third (or $86 billion in 2005) of paid out-of-pocket health expenditures. Kjos, *supra* note 16. McKinsey consultants recently offered a $45 billion estimate in credit card self-pay health spending, but predicted a multiplication of this figure in the near future. LeCuyer & Singhal, *supra* note 51. Some of these estimates preceded the financial crisis.

57. 42 U.S.C. § 1395dd (2006). Emergency intake personnel are also prohibited from delaying treatment to inquire about a patient's ability to pay or insurance status. *See* § 1395dd(h).

58. For evidence that emergency room services are perceived as relatively unprofitable, see Jill R. Horwitz, *Making Profits and Providing Care: Comparing Nonprofit, For-Profit, and Government Hospitals*, 24 HEALTH AFF. 790, 792, exhibit 1 (2005).

59. Michael S. Friedberg, *Patient Access: A New Face for the Revenue Cycle*, HEALTH CARE FIN. MAN., March 1, 2007, at 90.

60. *Growing Focus on ED Collections: Here Are Tips*, HOSP. ACCESS MGMT., Apr. 1, 2009.

61. *Id.*

62. *See, e.g.*, Milt Freudenheim, *Creating Financing; Medicine on Installment Plan: Doctors*

"arrangers" of credit.[63] By contrast, providers who directly extend credit may be required to comply with and face potential liability under federal truth-in-lending laws and regulations,[64] as well as state credit laws or deceptive practices

Offering Loans at 0%, N.Y. TIMES, Aug. 30, 2007, at A1 (describing medical financing as "one of the fastest-growing parts of consumer credit, led by lending giants like Capital One and Citigroup and the Care Credit Unit of General Electric"); Grow & Berner, *supra* note 36 (referring to the "little-known medical debt revolution" and reporting that "[m]any patients say they don't realize their debts are being shifted to such interest-charging middlemen as GE Money Bank"); Hansen, *supra* note 41. Recent examples of medical-specific credit products, designed largely to supplement insurance, include the CarePayment card by Aequitas Capital Management, Care Credit by General Electric, Capital One, Citigroup, Hospital Expense Loan Program (HELP Financial), U.S. Bank's medical card, Complete Care, and MedKey Inc. *See* Schoen et al., *supra* note 26, at w307 (referring to medical debt as new growth industry); *Card Industry Looks To Seal a Health Care Payments Gap*, CARDS & PMTS (2007) (discussing CarePayment credit cards); Grow & Berner, *supra* note 36 (reporting on interest rates charged by medical credit providers, but noting that interest is not always charged when parties buy the debt at discount and expect to collect full amount); Hundley, *supra* note 50 (reporting on hospital relationships with medical credit providers and interest rates as compared to some in-house payment plans); *Overdose of Debt: Lenders Push Risky Credit for Everything from Cancer to Botox*, CONSUMER REPS., July 2008, at 14 (listing medical credit "pitches" to patients and doctors); MedKey Healthcare Finance, http://www.medkeyinc.com (last visited Apr. 8, 2010) (offering line of credit for medical bills, 90 days interest-free, 5.99% thereafter).

63. Federal consumer credit laws no longer include arrangers of credit under the Truth in Lending Act (TILA). King v. Second City Constr. Co., 1997 U.S. Dist. LEXIS 15696, at *9 (N.D. Ill. Sept. 30, 1997) ("At one time, the definition of creditor under the TILA and its implementing regulations included 'arrangers of credit.' However, that portion of the definition was deleted from both the statute and the regulations in 1982."). We could find no evidence that state loan arranger or broker statutes have been applied to medical providers. For an example of a state broker statute, see, for example, IND. CODE ANN. § 23-2-5-3(c) (Lexis Nexis 2009) (defining a loan broker as "any person who, in return for any consideration from any source procures, attempts to procure, or assists in procuring, a loan from a third party or any other person, whether or not the person seeking the loan actually obtains the loan").

64. 12 C.F.R. § 226.2(a)(17) (2008) (portion of regulation Z defining creditor as "a person (A) who regularly extends consumer credit that is subject to a finance charge or is payable by written agreement in more than 4 installments (not including a down payment), and (B) to whom the obligation is initially payable, either on the face of the note or contract, or by agreement when there is no note or contract"). *See also* Bright v. Ball Memorial Hosp., 616 F.2d 328, 335 (7th Cir. 1980) (finding that a hospital can be "creditor" for purposes of TILA); James H. Backman, *Consumer Credit and the Learned Professions of Law and Medicine*, 176 B.Y.U. L. REV. 783 (1976); William D. Warren & Thomas R. Larmore, *Truth in Lending: Problems of Coverage*, 24 STAN. L. REV. 793, 819-20 (1972) (discussing refusal to exempt medical providers and other "professionals" from TILA, but noting some accommodations for installment payment practices); Edlin, *supra* note 49

statutes.[65] This divergence in legal consequences not only contributes to providers' reluctance to charge interest when they do extend credit,[66] but also increases the attractiveness of matching patients with specialty credit products.

Medical credit products are becoming integrated with health care finance more generally: some providers of insurance products or self-insuring companies

---

(recommending disclosures to comply with TILA if providers use payment plans); Gugliemo, *supra* note 42; Hansen, *supra* note 41; Moore, *supra* note 49 (recommending late fees rather than interest to ease TILA compliance); *Practice Pointers: When Patients Can't Pay*, MED. ECON., June 3, 2005 (discussing legal implications of falling within consumer credit definitions); Todd Stein, *Patients, Pay Up! You'd Better Have a Financial Policy*, PHYSICIANS PRAC., Mar. 2005, *available at* http://www.physicianspractice.com/index/fuseaction/articles.details/articleID/629.htm (warning providers that if they charge interest, they should have an attorney review their policy for compliance with lending laws: "Because the rules are complex, most practices choose not to charge interest on balances owed.").

65. *See, e.g.*, Anderson v. Southeast Ala. Med. Ctr., 381 So. 2d 68, 70 (Ala. Civ. App. 1979) (finding that defendant hospital was a "creditor" under ALA. CODE § 5-19-1(3) (1975), but not imposing finance charges for outstanding debt). *See also* Richard M. Alderman, *The Business of Medicine-Health Care Providers, Physicians, and the Deceptive Trade Practices Act*, 26 HOUS. L. REV. 109, 140 (1989).

66. The AMA Code of Medical Ethics, which is non-binding on physicians, suggests that providers notify patients of the possibility of charging interest in advance of treatment. *See* AMA Code of Medical Ethics, Opinion 6.08 (Interest Charges and Finance Charges) (1994), *available at* http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion608.shtml. But charging interest does not seem to be the norm among medical providers. *See* Edlin, *supra* note 49 (reviewing negative aspects of doctors imposing finance charges); Moore, *supra* note 49 (citing consultant characterizing charging interest as "touchy area" and discouraging it); Stein, *supra* note 64 ("[M]ost practices choose not to charge interest on balances owed."); Hansen, *supra* note 41 (citing a consultant reporting that "many" medical practices do not charge interest, but that "it is prevalent for expensive medical procedures" and another consultant saying that "it's common for physicians to collect bills without charging interest," and a practice group reporting that it charges 6% annual interest if the bill is unpaid for more than six months); Cheryl L. Toth, *Payment Plans for Patients: Better Collections for You*, PHYSICIANS PRAC., Jan./Feb. 2003, *available at* http://www.physicianspractice.com/index/fuseaction/articles.details/articleID/365.htm (discussing downsides of charging interest). For a recent controversial example, see Press Release, The Office of Attorney General Lori Swanson, Attorney General Lori Swanson Files Suit Against Allina Health System for Charging Usurious 18% Interest on Medical Debts (Jan. 22, 2009), http://www.ag.state.mn.us/Consumer/PressRelease/090122AllinaInterest.asp (alleging provider charged 18% interest on outstanding balances up to $4,999 and 12% on balances from $5,000 to $9,999 in violation of Minnesota law); MINN. STAT. § 334.01(1) (2008) (stating the legal standard interest rate of 6% annually and maximum rate of 8%).

join with banks to offer lines of credit for the self-pay portion of bills.[67] Health savings accounts (HSAs), part of high-deductible health plans, may be directly linked with credit or debit cards.[68] The justification for offering adjunct credit products is to allow consumers to bridge the gap between large deductibles and more meager HSA contents.[69] Several companies have filed applications for business method patents for HSA payment systems with credit line components, suggesting significant investment in the combination of financing approaches.[70]

---

67. *See, e.g.*, Freudenheim, *supra* note 62, at A21 ("Big insurers, too, are devising new financing plans with various payback options."); John Carroll, *Banks Give Insurers an Offer Most of Them Cannot Refuse*, MANAGED CARE, July 2006, http://www.managedcaremag.com/archives/0607/0607.banks.html ("Companies with self-funded or self-insured health plans started offering employees a line of credit" from a bank that is a subsidiary of UnitedHealth Group, "the OnePay Plan."); *One Bill, OnePay: Pilot Program Simplifies Billing for Consumers and Physicians*, HUB MAG., 2006, http://www.hubmagazine.net/pdfs/014909_OnePay.pdf (discussing a pilot program in which the interest rate was set at the prime rate, and consumers made payment through payroll deductions). *See generally* E. Haavi Morreim, *High-Deductible Health Plans: Litigation Hazards for Health Insurers*, 18 HEALTH MATRIX 1, 30 (2008) (describing OnePay plan and potential problems); LeCuyer & Singhal, *supra* note 51 (recommending that insurance providers offer credit lines to policy holders); Sarah Rubenstein, *In New Health Plan, Patients Pay Their Share—Or Else*, WALL ST. J., Mar. 13, 2006, at B1.

68. *See, e.g.*, Jennifer Roy, *HSA Lines of Credit*, HSA HEALTHLINE (Choice Fin., Fargo, N.D.), Nov. 2007, *available at* http://www.choicefinancialgroup.com/hsa/healthline newsletters /nov07.pdf (providing terms for Choice Financial's line of credit); Chase Health Savings Account, Healthcare Line of Credit, http://www.choicefinancialgroup.com/files/HSA Guide.pdf (last visited Apr. 9, 2010) (setting rate at 13.99% for interest rate on credit line); Provident Bank, Health Savings Account (HSA) Line of Credit, https://www.mtb.com/personal/healthsavingsaccount/Pages/HSA.aspx (last visited Apr. 9, 2010) (describing loans up to $10,000 and encouraging use of line of credit as overdraft protection); Visa Health Savings Account Card, http://usa.visa.com/personal/cards/prepaid/healthcare-card.html (last visited Apr. 9, 2010) (combining line of credit with health insurance identification card, capability of accessing other accounts, and reimbursement arrangements); US Bank, Health Savings Solution Product Guide, https://healthsavings.usbank.com/usbankhsa/forms/Health%20Savings%20Solution%20product%20guide.pdf (last visited Apr. 9, 2010) (including line of credit); *see also* CARDS & PMTS, *supra* note 62; Tony Miller, *Getting on the Soapbox: Views of an Innovator in Consumer-Directed Care*, 25 HEALTH AFF. w549, w550 (2006); *Companies Offer Nation's First Credit Line to Owners of Health Savings Accounts*, BUS. WIRE, June 27, 2005; Haugh, *supra* note 18, at 18.

69. *See, e.g.*, *UMB Healthcare Services' Dennis Triplett Offers Perspective on HSA Line of Credit Solution*, BUS. WIRE, Aug. 2, 2006, *available at* http://www.allbusiness.com/banking-finance/banking-lending-credit-services-cash/5345119-1.html.

70. *See, e.g.*, Method for Maintaining & Providing Health Savings Accounts (HSAs), U.S. Patent Application No. 20060200397 (filed Sept. 7, 2006).

In summary, the current health care system features constant, regular financial transacting between providers and their patients regardless of patients' insurance status. The sizeable number of patients with difficulty handling self-pay obligations imposes additional financial risks on providers. The recommended approaches to managing these risks in light of legal and practical considerations encourage early payoff of health care providers and seek to avoid later direct legal enforcement to the extent possible.

The practices that providers adopt to shape their financial transacting affect the ways in which researchers can measure patients' medical burden. We turn to this matter in the following subsection, focusing specifically on the measurement of burden for people who have filed for bankruptcy.

2. Measuring Medical Burdens of Bankruptcy Filers

Researchers have differed in their methods of identifying medical bills and medical problems among people who file for bankruptcy.[71] Most bankruptcy studies use self-reported information in one form or another.[72] Elizabeth Warren, Jay Westbrook, and Teresa Sullivan honed the approach of using written questionnaires and other survey methods in the personal bankruptcy context.[73] With respect to medical problems, Warren, Himmelstein, Woolhandler, and Thorne wrote a paper that used data from the 2001 Consumer Bankruptcy Project ("2001 CBP") studying filers in five states. A key data source was written questionnaires, on which respondents could indicate whether they had out-of-pocket medical expenses of at least $1,000 in the two years prior to bankruptcy, medical uses of second mortgages, and health insurance coverage. Respondents also could pick reasons for bankruptcy (including illness or injury) from a list of

71. For literature reviews, see Melissa B. Jacoby, Teresa A. Sullivan & Elizabeth Warren, *Rethinking the Debates over Health Care Financing: Evidence from the Bankruptcy Courts*, 76 N.Y.U. L. REV. 375, 377 (2001) (summarizing earlier literature and referring to the bankruptcy system as an "overlooked source of information for purposes of the health care finance policy debates"); Melissa B. Jacoby, *The Debtor-Patient Revisited*, 51 ST. LOUIS U. L.J. 301 (2007) (distinguishing studies of debt from studies of medical-related financial problems).

72. Most general population studies that include bankruptcy-related questions use self-reported information. *See, e.g.*, CUNNINGHAM, *supra* note 28; USA Today/Kaiser Family Foundation/Harvard School of Public Health, *supra* note 36; APARNA MATHUR, AM. ENTER. INST., MEDICAL BILLS AND BANKRUPTCY FILINGS (2006), http://www.aei.org/docLib/20060719_MedicalBillsAndBankruptcy.pdf.

73. TERESA A. SULLIVAN, ELIZABETH WARREN & JAY LAWRENCE WESTBROOK, AS WE FORGIVE OUR DEBTORS (1989) (describing filers from 1981).

pre-coded options.[74] The 2001 CBP undertook follow-up telephone surveys with a subset of the filers that reviewed out-of-pocket costs and medical diagnoses in greater detail.[75] Himmelstein and his coauthors analyzed that dataset and concluded in their first paper that nearly half of bankruptcies met at least one criterion for characterization as a "major medical bankruptcy" and more than half met a slightly more expansive definition of "any medical bankruptcy."[76]

Published in the peer-reviewed journal *Health Affairs* as a web exclusive, the Himmelstein paper was released just as Congress was restarting deliberations on a major bill to restrict bankruptcy relief. Senator Grassley, a sponsor of that bill, requested that a division of the DOJ (the Executive Office for United States Trustees) determine the validity of the Himmelstein findings.[77] Assistant Attorney General William Moschella submitted a short letter and summary reporting the frequency and amounts of medical debt detectable in court records in a sample of "no-asset" chapter 7 cases.[78] Those figures are reprinted in Table 1 in Part III; as noted in the introduction, Attorney General Moschella's letter and summary conveyed that the medical debt impact was modest. The letter closed

74. David Himmelstein et al., *Illness and Injury as Contributors to Bankruptcy*, HEALTH AFF. W5-67 (Web Exclusive Feb. 2, 2005).

75. *Id.* at W5-69. Among the respondents who participated in telephone interviews and said they had medical reasons for bankruptcy, the average amount of out-of-pocket expense (excluding premiums) in the year leading to bankruptcy was over $3,500. Out-of-pocket expense since illness onset averaged approximately $12,000. *Id.*

76. *Id.* at W5-66. Other studies have used the same data for analysis, *see, e.g.*, Jacoby & Warren, *supra* note 33 (reanalyzing 2001 CBP data to show different ways to measure medical-related bankruptcy), or adopted similar survey instruments for use on different populations. *See* WATSON, *supra* note 26 (using some CBP questions to study Missouri debtors); Ezekial Johnson & James Wright, *Are Mormons Bankrupting Utah? Evidence from the Bankruptcy Courts*, 40 SUFFOLK U. L. REV. 607 (2007) (replicating methods, finding that 61% in study of filers in Utah reported that medical problems contributed to their bankruptcy filings).

77. 151 CONG. REC. S2053, S2078 (Mar. 4, 2005) (reprinting Letter from William E. Moschella, Assistant Att'y Gen., U.S. DOJ, to Charles E. Grassley, U.S. Sen. (Feb. 10, 2005)). The letter characterized the Himmelstein et al. definitions of medical bankruptcy as "very broad" and highlighted that the article's broader definition of medical bankruptcy included drug addiction and uncontrolled gambling, *id.*, although those factors were nominal additions to the overall count.

78. For a description of the distinction between an "asset case" and a "no-asset case," see Dalié Jiménez, *The Distribution of Assets in Consumer Chapter 7 Bankruptcy Cases*, 83 AM. BANKR. L.J. 795 (2009). An asset case is one in which there is property to distribute to unsecured creditors after secured creditors are paid any allowed secured claims and the debtor retains exempt property. *Id.* at 798. Accordingly, in a "no-asset case," debtors have no unencumbered non-exempt assets for distribution to unsecured creditors. *Id.* at 797.

by stating, "[T]he conclusion that almost 50 percent of consumer bankruptcies are 'medical related' requires a broad definition and *generally is not substantiated* by the official documents filed by debtors."[79]

Assistant Attorney General Moschella's observation is based on the following method: whether coders could find holders of claims that had demonstrably medical names on "Schedule F," a list of claims that bankruptcy filers must submit to the court.[80] On Schedule F, debtors list the amount of non-priority unsecured claims (claims owed to general creditors who lack collateral for these debts) owed at the time of filing and the identity of the holders of such claims at that time. The DOJ's summary of findings correctly noted that using Schedule F would exclude bills owed on the date of bankruptcy to a creditor with a non-medical name, but neither the summary nor cover letter highlighted or explained the relevance of this limit for those who would be unfamiliar with the ramifications.[81]

The court record method was not without precedent. Early studies of the bankruptcy system under the 1978 Bankruptcy Code used court records to start examining filers and the system.[82] Over time, researchers interested in the circumstances of bankrupt families began to identify pros and cons to using court records.[83] As studies of bankruptcy filers have evolved and use of consumer credit for various household purposes has grown substantially, so have the

---

79. *See supra* note 77 (emphasis added).

80. *See* Official Bankruptcy Forms, Schedule F: Creditors Holding Unsecured Nonpriority Claims (Dec. 2007), *available at* http://www.uscourts.gov/rules/BK Forms 1207/B_006F_1207f.pdf. *See also supra* note 77.

81. *See supra* note 77. After the Bankruptcy Abuse Prevention and Consumer Protection Act was enacted, the Director of the United States Trustee Program was circumspect about what could be gleaned from Schedule F about medical burden. He observed that the Program did not have "definitive data" on the amount of medical debt owed by bankruptcy filers and that, even with data-enabled forms that the Program hoped to develop, medical debt would be difficult to measure through those forms. *Hearing on Working Families in Financial Crisis: Medical Debt and Bankruptcy*, 110th Cong. 4-5 (2007) (statement of Clifford J. White III, Director, Executive Office for United States Trustees), *available at* http://judiciary.house.gov/hearings/July2007/white070717.pdf. White's testimony cited 2003 data in which 46% of the filers in no-asset chapter 7 cases included medical debt on Schedule F, about 78% of them reported debt less than $5,000, and fewer than 1% of the cases represented more than one third of the total medical debt. *See id.* at 4.

82. Examples include SULLIVAN ET AL., *supra* note 73 (regarding filers from 1981); Susan D. Kovac, *Judgment-Proof Debtors in Bankruptcy*, 65 AM. BANKR. L.J. 675 (1991) (describing filers from 1985-1986).

83. *See, e.g.*, Jacoby et al., *supra* note 71 (reviewing these concerns).

number of objections to measuring medical burden with court records.[84]

Nonetheless, certain U.S. senators characterized the DOJ response as a debunking of the Himmelstein study's finding that medical problems contributed to about half of bankruptcies. Senator Grassley issued a press release strongly suggesting that assertions of high percentages of medical-related bankruptcies were "myth."[85] Senator Sessions also used the DOJ study to suggest that these percentages were a "fiction."[86]

---

84. *See, e.g.*, 151 CONG. REC. S6010 (May 26, 2005) (reprinting Letter from David Himmelstein, Assoc. Professor of Med., Harvard Med. Sch., et al. to Charles E. Grassley, U.S. Senator (Feb. 14, 2005)). This letter identified a list of debts that likely would be excluded from the analysis cited in the Moschella letter as well as the implications of including only no-asset chapter 7 cases.

85. Senator Grassley said:

> Make no mistake, misrepresentations about this legislation have been running rampant by those who oppose any meaningful bankruptcy reform. I've been in politics a long time, and I know that political criticism is never inhibited by ignorance. For instance, the statistical analysis in the U.S. Trustee's office examined over 5000 bankruptcy cases and found that under one-half listed medical debts of any sort. And those filers who did list medical debts, on average, listed under $5000 in medical debts. So much for the myth that most bankruptcies are driven [sic.] medical costs. The fact is there are abusers out there. The fact is S. 256 doesn't harm bankrupts with large medical debts. Let's stop the abuse. Let's return to common sense. Let's enact bankruptcy reform now, before the abuse gets worse.

Press Release, Opening Statement of Senator Chuck Grassley at the Bankruptcy Reform Hearing (Feb. 10, 2005), http://grassley.senate.gov/news/Article.cfm?customel_dataPageID_1502=9716.

86. Senator Sessions said:

> This is what the United States Trustee Program found in a much more extensive survey. . . They were asked to survey the filings in their districts to find out what you list on your filing as your debts, who you owe. You actually list who it is. So, if it is a doctor bill, it is on there. If you don't put it on there you don't wipe out that debt and you remain obligated to pay it, so everybody puts every debt they have on the list so it can be wiped out when they file bankruptcy. What they found was, this professional study of 5,000 cases, not interviewing debtors but looking at what they put on their form, they found that only slightly more than 5 percent of the total unsecured debt reported in those cases was medically related. Only 5 percent was medically related. This is not 50 percent of the cases in bankruptcy being caused by medical—only 5 percent of them, of the total debt, was medical . . . For some people there is no doubt that medical debts are a cause for bankruptcy. I do not doubt that. But this idea that. . .we ought to assume that there is no fraud and abuse in bankruptcy and the idea that everybody is in bankruptcy because of medical debts is just not so.
>
> It is just not; it is a fiction. We need to get it out of our heads.

151 CONG. REC. S2077 (daily ed. Mar. 4, 2005). Senator Cornyn echoed the sentiments, saying:

> First, let me say to my friend, the Senator from Alabama, how much I appreciate his eloquence on this bill and his very successful attempt to explain to the American people,

Likewise, academic critics of the Himmelstein study highlighted the DOJ findings and lent credence to the court record method as a valid and useful measure of medical bill burden.[87] Within a lengthier critique of the Himmelstein study, two health care finance experts included a full paragraph identifying the DOJ findings as a counterpoint.[88] They used the DOJ findings to illustrate that medical debt is only a small proportion of bankruptcy filers' financial obligations.[89] In written testimony for a congressional hearing, a law professor described and cited the DOJ findings for the proposition that only a few cases have sufficiently high medical debt for it to be properly characterized as a cause of bankruptcy.[90]

By 2009, interest in the scope of the medical bankruptcy problem intensified. Early in the year, then-President-Elect Obama's economic agenda included making it easier for people in medical-related bankruptcies to receive a discharge of debt.[91] In the summer of 2009, Himmelstein, Thorne, Warren, and Woolhandler released a new study estimating that 62% of bankruptcy filings could be counted as medical-related.[92] That study's release dovetailed with debates on health care finance reform. In late July 2009, the House Judiciary Committee called a hearing to discuss whether the health care system was bankrupting American families. Representative Conyers cited the 2009

> as well as to us, what is at stake here, and to knock down some myths that are being used to try to worry people when, in fact, there is no reason for people to be worried about this legislation.

Id.

87. These writings also identified a range of other criticisms, unrelated to the data sources, which are beyond the scope of this Article.

88. David Dranove & Michael Millenson, *Medical Bankruptcy: Myth Versus Fact*, 25 HEALTH AFF. w78 (2006) (citing DOJ study and conclusion without qualifications).

89. *Id.*

90. *Working Families in Financial Crisis: Medical Debt and Bankruptcy: Hearing Before the Subcomm. On Commercial and Administrative Law of the H. Comm. on the Judiciary,* 110th Cong. 27-29, 32 (July 17, 2007) (statement of Todd J. Zywicki, Professor, George Mason Univ. Sch. Of Law).

91. *See* Posting of Sarah Rubenstein to Wall St. J. Health Blog, *Obama Aims To Help Patients Wipe Away Medical Debts*, http://blogs.wsj.com/health/2009/01/07/obama-aims-to-help-patients-wipe-away-medical-debts/ (Jan. 7, 2009, 2:06PM EST) (citing The Obama-Biden Plan, http://change.gov/agenda/economy_agenda (last visited Apr. 2, 2010) ("Obama and Biden will create an exemption in bankruptcy law for individuals who can prove they filed for bankruptcy because of medical expenses. This exemption will create a process that forgives the debt and lets the individuals get back on their feet.")).

92. Himmelstein et al., *supra* note 7.

Himmelstein study as evidence that health care finance reform was urgently needed.[93] But a witness at the hearing from the American Enterprise Institute returned to the DOJ findings, which she described as the "closest comparable survey," to cast doubt on Himmelstein's findings.[94]

No one has systematically examined the DOJ's court record method and why exactly it differs from the Himmelstein study's findings. We undertake that examination here by imposing both methods on, and collecting both types of information from, a single population.

B. Data for the Current Study

We analyze information from the 2007 Consumer Bankruptcy Project ("2007 CBP"), a nationally representative study of approximately 2,500 personal bankruptcy cases.[95] The response rate to the questionnaire portion was 50%.[96] Respondents and non-respondents shared similar characteristics on variables such as income, debt, assets, monthly expenses, and prior bankruptcies.[97] The dataset has a slight underrepresentation of chapter 13 cases, which we correct with weighting when necessary.[98] The median age of a filer in the 2007 CBP is 43, older than the median in the general U.S. population.[99] Median household income

93. *Medical Debt: Is Our Healthcare System Bankrupting Americans: Hearing Before the Subcomm. on Commercial and Administrative Law of the H. Comm. on the Judiciary*, 111th Cong. 4 (July 28, 2009) (opening statement of Rep. John Conyers, Jr.), *available at* http://judiciary.house.gov/hearings/pdf/Conyers090728.pdf.

94. *Id.* at 6-7 (written testimony of Aparna Mathur, Research Fellow, American Enterprise Institute), *available at* http://judiciary.house.gov/hearings/pdf/Mathur090728.pdf.

95. Robert M. Lawless et al., *Did Bankruptcy Reform Fail? An Empirical Study of Consumer Debtors*, 82 AM. BANKR. L.J. 349, 391 (2008) (describing the methods of the 2007 CBP).

96. *Id.* at 392.

97. *Id.* at 396.

98. The average Schedule F medical debt is significantly higher for chapter 7 filers than chapter 13 filers, but there was no chapter-related difference in the *likelihood* of reporting medical debt on Schedule F. In addition, the median Schedule F medical debt for chapter 7 and chapter 13 filers is not significantly different ($1,698 for chapter 7 filers versus $1,384 for chapter 13). Filers in the two chapters also had a similar distribution of Schedule F debts (as well as questionnaire expense) across the range, with the differences skewing the averages likely coming largely from the group of filers with Schedule F medical debts $10,000 and above. Thus, for most of our analysis, we combine the two kinds of cases without weighting, but indicate where we have used weighting.

99. Deborah Thorne, Elizabeth Warren & Teresa A. Sullivan, *The Increasing Vulnerability of Older Americans: Evidence from the Bankruptcy Court*, 3 HARV. L. & POL'Y REV. 87, 92 (2009). The median age in the general population in 2007 was only 36.1. *Id.* at 93, fig.1.

of the sample is less than $28,000.[100] Median net worth is substantially negative (nearly -$24,400).[101] About half were homeowners when they filed for bankruptcy, and among them, median mortgage debt was just over $100,000.[102]

Respondents completed written questionnaires that included demographic information and other information about their pre-bankruptcy circumstances.[103] For all respondents, the 2007 CBP also extracted information on approximately 200 variables from court records, many of which are debtor-supplied under penalty of perjury. The 2007 CBP conducted follow-up telephone surveys with approximately 1,000 respondents within a year after they filed for bankruptcy.[104]

The approach taken in this Article is unique in several respects. First, we approximate the DOJ method of identifying medical debts from Schedule F in the court records.[105] This enables replication and closer scrutiny of the DOJ court record method. Second, we are able to isolate filers who specifically identified medical *bills* as a reason for bankruptcy as compared to lost income or the other ways medical problems can contribute to financial distress.[106] In addition, we use

100. Lawless et al., *supra* note 95, at 359, 404. The mean was under $31,000. *Id.* at 404. In terms of income distribution, about 85% of the 2007 CBP respondents had incomes below the U.S. national median household income in 2007 (undifferentiated by household size), and more than three in ten had incomes below the "poverty rate" for a family of four. For national median income figures, see CARMEN DENAVAS-WALT, BERNADETTE D. PROCTOR & JESSICA SMITH, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2007, 5, 7 (2008), *available at* http://www.census.gov/prod/2008pubs/p60-235.pdf. For the poverty guidelines, see U.S. Dept. of Health & Human Servs., The 2006 HHS Poverty Guidelines, http://aspe.hhs.gov/POVERTY/06poverty.shtml (last visited Apr. 10, 2010). The income distribution of bankruptcy filers in the 2007 CBP is shown in Lawless et al., *supra* note 95, at 360 fig.2.

101. Lawless et al., *supra* note 95, at 371, 405.

102. *Id.* at 365.

103. *Id.* at 399-402 (reproducing questionnaire).

104. *Id.* at 396. As was previously noted, the telephone survey subsample is not significantly different from the whole regarding variables such as "filing status, filing chapter, total assets, total debts, priority debts, monthly income, [and] home value." *Id.* at 396 n.177.

105. The specific codebook instruction was as follows:

> This number represents the sum of debts that appeared to be owed to medical providers. Debts were counted as medical debts if they were owed to hospitals, doctors, labs, nursing homes and other treatment facilities, pharmacies, medical collection agencies, and anything else that looked related to health, medical, wellness, or sickness.

106. Jacoby & Warren, *supra* note 33, at 563 (2006) (discussing the importance of income effects of illness or injury). Notably, for this Article, we are not seeking a comprehensive count of cases that could be construed as medical bankruptcies. In this respect, our study is distinct from the aim of Himmelstein et al., *supra* note 7. Still, the explicit "medical bill reason" for bankruptcy

a more detailed series of questions about out-of-pocket medical expenses that reveal respondents' medical bill management techniques. Specifically, the questionnaire asked whether respondents were directly responsible for medical bills uncovered by insurance within the two years leading up to the bankruptcy filing.[107] Respondents who said "yes" were asked additional follow-up questions:

> How did you, or a spouse or partner, pay for the medical bills or prescriptions that were not covered by insurance? Did you: Check all that apply: Pay with a cash, check, or debit card; Pay with a regular credit card; Pay with a medical credit card (such as CitiHealth Card, CareCredit, or MediCredit); Pay with money from a home equity loan or line of credit; Agree to a payment plan with the medical provider; Something else (please specify).

The latter questions help us scrutinize the absence of a medical bill from the court records and offer a window into the management practices explored in Part II.A. For this Article, we report findings for all of the responses, and primarily discuss the options that most directly relate to discrepancies between the court record method and the survey method: cash, credit card, and home equity loans.[108] Also, whereas prior surveys asked only whether respondents incurred more than $1,000 in out-of-pocket expenses, respondents in this study were asked to identify the amount that they paid out-of-pocket within specified ranges: less than $1,000; $1,000-$5,000; $5,001-$10,000; and more than $10,000. This greater specificity enables a better comparison to the court record method and facilitates a more in-depth analysis of medical burden. Overall, our innovation is to deploy both the survey method and the court record method on the same dataset, and to use new methods of analysis to undertake this comparison.

---

helps identify filers who are likely to have some non-trivial obligation. If court records are a useful source of information about medical burden, then we at least should be able to find evidence of substantial medical bills in the records of these respondents.

107. The exact language of question 18 was: "During the TWO years before the bankruptcy, were you, or a spouse or partner, FINANCIALLY responsible for ANY medical bills, INCLUDING prescription medication or co-payments, that were NOT covered by insurance" (emphasis in original). The question did not ask the respondent to indicate the specific source of the cost (doctor, hospital, prescription drugs, etc.).

108. A more in-depth evaluation of payment plans and "something else" (other forms of payment for medical bill payment not discussed in this Article) will be reported in a separate paper.

III. ANALYSIS AND FINDINGS

We start by reporting Schedule F medical debt. The left column of Table 1 replicates the information the DOJ reported to Congress. The middle column represents our 2007 CBP data limited to no-asset chapter 7 cases (liquidation cases) to most closely match the DOJ sample. The right column represents the 2007 CBP full core sample that also includes chapter 13 (repayment plan) cases.

TABLE 1: DOJ AND 2007 CBP SAMPLE COMPARISONS

DOJ Sample (No-Asset 7s Closed Between 2000 and 2002, Excluding N.C. & Ala.)	**2007 CBP Sample (No-Asset 7s Only)**	**2007 CBP Sample (7s and 13s)**
All Cases		
N=5,203	*N= 1,719*	*N=2,438*
54% listed no medical debt.	**48.4%** listed no medical debt (**50.6%** if including cases with missing data).	**49.8%** listed no medical debt (**50%** if including cases with missing data).
Medical debt accounted for **5.5%** of the total general unsecured debt.	Medical debt accounted for **6.2%** of the total general unsecured debt ($5,851,877 of $93,095,955).	Medical debt accounted for **5.6%** of the total general unsecured debt ($7,727,494 of $136,353,023).
90.1% reported medical debts less than $5,000.	**86.2%** reported medical debts less than $5,000 (**88.6%** if inflation-adjusted to $5,734).	**88%** reported medical debts less than $5,000 (**92.3%** if inflation-adjusted to $5,734).
1% of cases accounted for **36.5%** of all medical debt.	**1%** of cases accounted for **37.3%** of all medical debt.	**1%** of cases accounted for **35.4%** of all medical debt.
Less than **10%** of all cases represented **80%** of all medical debt.	**10%** of all cases represented **80.3%** of all medical debt.	**10%** of all cases represented **79.8%** of all medical debt.

Cases with Any Schedule F Medical Debt		
N=2,391	*N=853*	*N=1,271*
Among the cases with medical debt, the average medical debt was **$4,978** per case (**$5,709** in 2007 dollars).	Among the cases with medical debt, the average medical debt was **$7,483** per case.	Among the cases with medical debt, the average medical debt was **$6,313** per case (weighted by case type).
78.4% reported medical debt below $5,000 (average of **$1,212** for this group).	**73.4%** reported medical debt below $5,000; **76.3%** with inflation adjustment (average of **$1,405** for this group).	**76.1%** reported medical debt below $5,000; **78.8%** with inflation adjustment (average of **$1,394** for this group).
21.6% of cases accounted for **80.9%** of all medical debt.[109]	**21.6%** of cases accounted for **82.4%** of all medical debt.[110]	**21.6%** of cases accounted for **81.3%** of all medical debt.[111]
Medical debt accounted for **13.0%** of the total general unsecured debt.	Medical debt accounted for **12.3%** of the total general unsecured debt.	Medical debt accounted for **12.2%** of the total general unsecured debt.

Table 1 shows that the application of the court record method to the 2007 CBP dataset produces results that are very close to the DOJ results. With respect to the differences, Table 1 indicates that our court records include a slightly greater proportion of cases with Schedule F medical debt than the DOJ sample. Also, our sample's average medical debt, as indicated by the court records, is higher than the DOJ sample's, even after adjusting the numbers for inflation using the Consumer Price Index. These increases are consistent with rising medical costs (at a rate that is outpacing inflation) and self-pay obligations during the 2000s. Furthermore, because the DOJ reported neither median debt nor a distribution of the larger debts, it is possible that a small number of large debts explain the differences in averages.[112] In Figure 1, we report the distribution of the 8% of our sample with more than $10,000 in Schedule F medical debt,

109. We do not know why the DOJ reported this measure, but we replicate it in this Table.

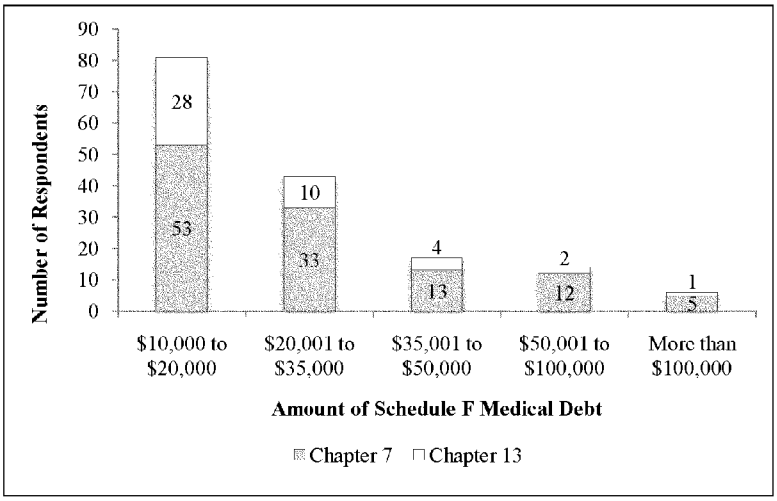
110. Additionally: 1% of cases account for 2.9% of the total medical debt, 10% of cases account for 67.4% of the total medical debt, and 20% of cases account for 81.4% of the total medical debt.

111. Again, we offer more figures: 1% of cases account for 2.5% of the total medical debt, 10% of cases account for 65.3% of the total medical debt, and 20% of cases account for 80% of the total medical debt.

112. We did not cap or remove outliers (disclosed in Figure 1 and note 113) because we found no evidence that the data in the DOJ report capped or excluded outliers. Earlier analyses by U.S. Trustee researchers appear to include the biggest Schedule F medical debts. *See* Ed Flynn & Gordon Bermant, *The Class of 2000*, AM. BANKR. INST. J., Oct. 2001, at 20 (reporting that "medical debt-figures were highly skewed by a few debtors with enormous medical debts.").

subdivided by chapter of bankruptcy filing.[113]

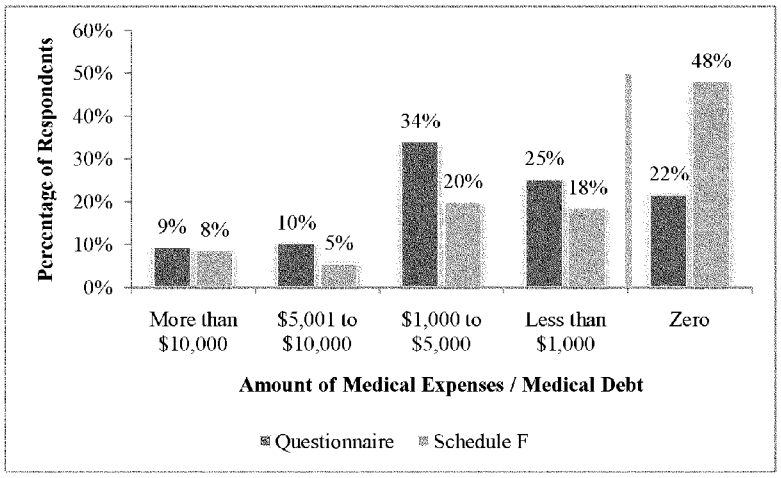
FIGURE 1: COURT RECORD MEDICAL DEBT OVER $10,000



Now that we have verified the similarities between the DOJ and 2007 CBP court records, we assess how well the court record method reflects pre-bankruptcy out-of-pocket expenses. To be included in a court record count of medical bills, a bill must have several qualities. It must be outstanding on the date of the bankruptcy filing. The filer must know about the bill to report it. Finally, the holder of the claim must be identifiable as medical to a third-party coder. Figure 2 displays medical expense of the 2007 CBP sample as indicated on the questionnaire (the survey method) and on Schedule F (the court record method. Importantly, the questionnaire asked only about expenses within two years prior to filing, whereas court records include claims incurred at any time before filing. This comparison thus suppresses even greater potential differences between the measures.

113. Of the filers with Schedule F medical debts over $100,000, four were just over this amount. Two had over $500,000. Three of these six filers were under twenty-five years old.

FIGURE 2: QUESTIONNAIRE-DERIVED MEDICAL EXPENSES AND SCHEDULE F MEDICAL DEBT



As Figure 2 shows, respondents had consistently lower levels of Schedule F medical debt than out-of-pocket medical expenses incurred within two years prior to filing.[114] The darker columns in Figure 2, which represent the questionnaire responses, show that nearly eight of ten respondents reported *some* out-of-pocket expenses within two years before filing, whereas medical debt could be found in the court records of only about five of ten respondents.

We examined the level of congruence between the court record and questionnaire measures in various ways. We established the Cronbach's alpha between the two variables, which is 0.609.[115] This level of congruence between the two measures is low enough to merit concern about the validity of using one

114. As illustrated by Figure 1, the distributions of the two measures are different. Written questionnaire expense forms a unimodal distribution, with a peak at $1,001 to $5,000. Schedule F medical debt manifests a different pattern, with about half the respondents having zero Schedule F medical debt, and greater than eight out of ten reporting $5,000 or less.

115. Cronbach's alpha is a measurement of how well two or more variables "hang together," or whether they measure a single latent construct. It is a measure of the reliability or consistency between the items at hand and is computed through the equation: $\alpha = \frac{N \cdot \bar{c}}{\bar{v} + (N-1) \cdot \bar{c}}$, where N is the number of items, $\bar{c}$ is the interitem covariance, and $\bar{v}$ is the average variance of the items. At the most basic level, Cronbach's alpha allows a researcher to evaluate how well one variable can replace another variable.

of these measures as a stand-in for the other.[116]

Next, we engaged in a filer-by-filer comparison of the two measures, which can be explained as follows. First, we compared the dollar value of the court record and survey measures for each filer. Doing this, we identified about a third of respondents in our sample (32%) who reported expenses on the questionnaire based on the survey method, but who had no medical debt in their court records. Documenting precise declines in dollar amounts when neither number is zero is more difficult because the questionnaire asked for an estimate of expense by category rather than an exact dollar amount. But we conservatively estimate that an additional 56% of the sample had less Schedule F medical debt than questionnaire-reported expenses.[117]

Our second filer-by-filer approach was to subtract a categorized measure of Schedule F medical debt from the questionnaire medical expenses category for each respondent.[118] For each case, this produced a nine-point scale ranging from

---

116. Generally, for comparing groups, a Cronbach's alpha of 0.70 to 0.80 or higher allows one to substitute one variable for another or to create a composite variable using the two measures. *See* J. Martin Bland & Douglas G. Altman, *Statistics Notes: Cronbach's Alpha,* 314 BRIT. MED. J. 572, 572 (1997).

117. To calculate the differences between questionnaire-reported medical expense and Schedule F medical debt for this particular finding, we subtracted each individual's reported expense from Schedule F medical debt, allowing us to compare the two reporting processes in a "pair-wise" manner. We needed to estimate a dollar amount for expense because the questionnaire asked only for categories of expenses. To estimate, we took the middle point of each expense category and used that to calculate the difference. For example, for the category $1,000 to $5,000, each respondent who reported expenses in that range was assigned a dollar debt amount of $3,000.50. For those who reported "more than $10,000" in expense, we assigned a dollar amount of $15,000 for purposes of this analysis. We believe that this is a particularly conservative estimate, given that on Schedule F, only half of the medical debts over $10,000 were also under $20,000. *See supra* p. 267, fig.1. To prevent these respondents from skewing the average difference between the two measures, we coded anyone who reported "more than $10,000" in expenses on the questionnaire *and* reported more than $10,000 in debt on Schedule F as having zero difference between the the two measures. Again, this allows our measure to be conservative.

118. The initial categories of expense, consistent with the ranges on the questionnaire, are coded as follows: "zero" means no expense, "1" means under $1,000; "2" represents expense between $1,000 and $5,000; "3" means expense between $5,001 and $10,000; and "4" represents more than $10,000. Subtracting the category of Schedule F debt from the category of questionnaire expense indicated by each respondent yields a number between "-4" and "+4." These numbers thus take on a meaning different from the original codes. For example, "zero" indicates the same category of expense on both measures, whether that category is no medical bills or over $10,000 in medical bills. When we use numbers in the appendices and going forward, we are referring to the result of this subtraction.

"-4" to "+4". A "-4" signifies that an individual had more than $10,000 in Schedule F medical debt and no questionnaire-reported expenses. A "+4" signifies that an individual had more than $10,000 in expenses on the questionnaire but no Schedule F medical debt. Appendix A shows the distribution of cases along this scale.

Most respondents fell within the same category of expenses under both measures or had more survey expenses than court record medical debt.[119] About one-fifth of the sample clearly had out-of-pocket expenses that were at least $1,000 more than their Schedule F medical debt, and often the difference was more than $5,000 or more than $10,000.[120] Cases fitting this description reveal most clearly the difficulties of relying on only court records; they also present the most interesting questions of how these households managed to reduce medical obligations in the midst of financial problems.

Although the additional analysis using this scale focuses on this fifth of respondents, we must emphasize that this is not a comprehensive count of people with serious medical burden. Some respondents with very significant medical

119. In the group of cases on the negative side of the scale, Schedule F medical debt exceeded the questionnaire reports of expense. We strongly suspect that these cases can be explained by the timing: the questionnaire asked for out-of-pocket expense only within the two years prior to filing. By contrast, Schedule F captures debts older than two years. Some particularly big debts are likely to be older. Notably, the presence of some cases with Schedule F debt older than two years and no recent out-of-pocket expense slightly dampens the discrepancy between these two measures of medical burden. A small number of such cases may not only raise the Schedule F medical debt averages, but also could make the highest dollar category of medical bills (*see supra* p. 268, fig.2) seem more consistent across measures than it really is. Although we believe this to be the dominant explanation, particularly for the cases in the "-4" and "-3" categories, we offer several others as well. While completing the exact dollar amounts on Schedule F, respondents may have been more likely to have been consulting direct documentation and to be completing the paperwork with a lawyer. A debtor who estimated even a few dollars less on the questionnaire could create a discrepancy when this measure was compared with Schedule F medical debt. Most discrepancies on the negative side of the scale are within a one or two point difference, and thus potentially are of smaller amounts. Also, some medical providers impose interest and/or finance charges. A respondent may have recalled and reported only principal on the questionnaire, while Schedule F lists the legally collectible debt that includes these additional amounts. Finally, although the coding error rate in this study was very low, error remains a possible explanation. For the rate, see Lawless et al., *supra* note 95, app.

120. We refer here to categories "+2," "+3," and "+4," which represent having out-of-pocket expenses of at least $1,000 more, $5,001 more, or $10,001 more, respectively, than Schedule F medical debt. The 20% figure is premised on missing variables being included in the total count. *See infra* app. A.

bills do not have verifiable discrepancies between the court record and survey measures. The most populous group of filers, whose expenses fall within the same category on both measures (as indicated by a "zero"), is very diverse regarding the amounts of medical debt these respondents faced both before and during bankruptcy. For example, 11% of all respondents who are a "zero" had over $10,000 of expenses in both the questionnaire and Schedule F. Such a respondent may have owed $50,000 in medical bills beforehand and could either continue to owe those bills to a provider or have reduced them to some amount above $10,000 identifiable as medical bills on Schedule F. An additional 4% had between $5,000 and $10,000 of medical expenses on both measures.[121] The average Schedule F medical debt for this "zero" group is just under $5,000, suggesting that individuals could, in fact, have paid thousands of dollars towards their medical debt while still occupying the same category of expenses on the two measures. Cases that are a single category greater as recorded by the survey method compared to the court record method (a "+1" in Appendix A) also mask a wide range of dollar differences and significant medical obligations for the same reasons.[122]

With respect to the fifth of the sample with the biggest verifiable discrepancies between the measures, a variety of possibilities could explain why the same debtor reported a large amount of medical expenses in the questionnaire but had little (or no) identifiable Schedule F medical debt. There is the standard problem that some medical providers or their debt collectors do not have medical-sounding identities that court record coders can discern.[123] Also, having more questionnaire-reported medical expenses than Schedule F medical debt could reflect that individuals on the brink of bankruptcy paid off some or all of their medical bills.[124] Such payoff would not necessarily signify a lack of

121. Forty percent of those who have the same category of medical expense on the questionnaire and medical debt on Schedule F had no out-of-pocket medical expenses or medical debt.

122. Those respondents that fall in the "+1" category have, on average, just under $1,000 in Schedule F medical debt and are most likely to report less than $1,000 in out-of-pocket expenses in the two years prior to filing. However, like the "zeros," these individuals could easily have large differences in the amount of expense and Schedule F medical debt. For example, some respondents indicated more than $10,000 in expense and reported between $9,000 and $10,000 in medical debt on Schedule F. It is possible that they had $10,001 in expenses and only paid off $100 of that debt, putting them in one category lower, but it also is possible that respondents had $25,000 in expenses and paid $15,100 off those expenses off prior to bankruptcy.

123. *See infra* note 152.

124. *See generally* Christopher Tarver Robertson, Michael Hoke & Richard Egelhof, *Get Sick, Get Out: The Medical Causes of Home Mortgage Foreclosures*, 18 HEALTH MATRIX 65, 90-92

financial burden from the bills; money is fungible and financially distressed families constantly make difficult choices about how to juggle expenses. Those filers most concerned with maintaining relationships with doctors could have fought very hard to pay these expenses while defaulting on other major obligations or satisfying those obligations using credit cards.[125] We can test the payoff hypothesis by looking at how the filers report managing their medical expenses, paying careful attention to the reported use of cash or cash equivalents.

In addition, some existing medical bills might simply be missing from Schedule F. This could be due to inadvertence,[126] a mistaken belief that insurance would fully cover a pre-bankruptcy procedure,[127] or a more intentional effort to hide the bankruptcy from a provider (who, if not listed, may not hear about the case) to avoid a feared disruption in health care.[128] The possibility that these circumstances explain the complete disappearance of a medical bill can be explored in part by looking at cases in which complete payoff would be most unlikely due to the size of the bills.

As the literature review suggested, reporting more expenses on the questionnaire than medical debt on Schedule F also could be due to the use of a credit card, home equity loan, or less formal borrowing to finance part or all of medical bills. In such an instance, out-of-pocket medical expenses, even if not paid fully by the time of filing bankruptcy, would not appear as Schedule F medical debt. Or, Schedule F medical debt would be lower in amount while debt to other creditors would likely be higher.

Discrepancies also could reflect that people overly attribute their financial problems on questionnaires to medical issues, which seem like a socially acceptable basis for overindebtedness.[129] Due to the methods employed here, this is less likely to explain the discrepancy in this study. The discrepancy reflected in

---

(2008) (reporting statements of foreclosure defendants that they had reallocated money intended for their mortgages toward medical bills).

125. It also is possible that providers gave respondents significant discounts for prompt payment that remain invisible to us, although those payments could have come from another credit source.

126. *See, e.g.*, *In re* Hocum, 119 B.R. 723 (Bankr. D.S.D. 1990) (granting debtor's post-discharge request to amend Schedule F to include accidentally omitted $262.94 hospital bill that had been assigned to debt collector).

127. For example, in one case, the debtor originally failed to list a medical debt on Schedule F because he thought Medicare would fully cover his cataract operation. He amended Schedule F once he realized his error. *See In re* Nosler, 2007 WL 4322315 (Bankr. M.D. Fla. Aug. 2, 2007).

128. *See* Jacoby et al., *supra* note 71, at 383.

129. See *id.* at 384-85 for discussions of overmedicalization generally.

Figure 2 and the text is based on a purely factual question about out-of-pocket obligation not covered by insurance. The 2007 CBP questionnaire did not ask people about "medical *debt*," which could be susceptible to inconsistent interpretations. Thus, the survey method variable for out-of-pocket expenses is straightforward. In addition, when respondents were asked to indicate their reasons for filing for bankruptcy—the place where overmedicalization would be most suspected—they did not merely check every available reason for filing that might be sympathetic. Indeed, only three out of ten respondents explicitly indicated medical bills as a reason for bankruptcy, even though far more reported substantial out-of-pocket medical expenses and had other indicators of distress.[130] In other words, it is possible that respondents have assigned too little responsibility to their medical problems for their financial downfall.[131] Even the greatest skeptics of the studies by Himmelstein et al. would be unlikely to suggest that the three out of ten people who reported medical bills as a reason for bankruptcy lacked any medical liability.

To begin our assessment of the possible explanations for discrepancies between the court record and survey methods, we look at the raw percentages on the use of cash, credit cards, and home equity loans for people with any medical expenses not covered by insurance.[132] These absolute percentages of credit usage presumably are dampened by the proximity to bankruptcy when some filers already have consumed their available credit.[133] But the overall frequency is less

130. Respondents in our sample selected an average of 4.33 reasons for filing out of a total of 19. Respondents who included the medical bill reason had a slightly higher average (5.75), but this can be explained by the fact that there was a strong association between reporting medical bills as a reason and the other medical reasons on the list of responses. For more information about the indication of medical reasons for filing, *see infra* p. 281, fig.6.

131. Jacoby & Warren, *supra* note 33.

132. The percentages in Figure 3 vary slightly from those in Appendix B because the questionnaire variables had fewer missing data points. Appendix B looks at these variables in combination with the court record variables, which reduced the number of observations. Also, Appendix B shows the difference in home equity loan use if one includes all who reported expense regardless of housing tenure.

133. We do not know the credit limits of our respondents. Because credit limits are not regularly reported in the general population, studies have used various techniques to estimate them. *See* ROBERT B. AVERY ET AL., AN OVERVIEW OF CONSUMER DATA AND CREDIT REPORTING, FED. RES. BULL. 58 (Feb. 2003), *available at* http://www.federalreserve.gov/pubs/bulletin/2003/0203lead.pdf. The most common approach is to use the highest balance ever reported as the credit limit. Using this technique, Avery et al. found in their 2003 paper that about 25% of revolving accounts in the general population had a credit limit below $1,000; 41% had a credit limit between $1,000 and $4,999; and only a very small percentage had a credit limit of $25,000 or more. *Id.*

important than the circumstances under which respondents used credit. Figure 3 shows medical bill payment methods broken down by those respondents who reported that medical bills were a reason that they filed for bankruptcy and those who did not. This breakdown demonstrates that respondents who indicated medical bills as a reason for filing use regular credit cards and home equity loans at a much higher level. In this Figure, the vertical axis shows the percentage of respondents with medical expenses.[134] The horizontal axis is a breakdown of the use of different methods of paying medical bills.

FIGURE 3: METHODS OF MANAGING MEDICAL BILLS

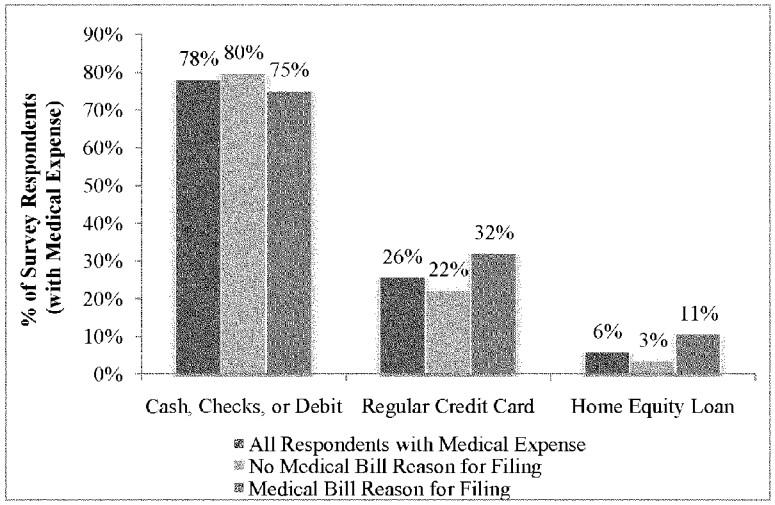


Figure 3 illustrates that those who reported medical bills as a reason for bankruptcy said they used home equity for medical bills nearly four times as frequently as the other respondents, and had a higher rate, by more than a third, of using credit cards to pay medical bills.[135] The markedly higher use of home

Looking at the overall profile of revolving accounts, the average credit limit was about $4,500. *Id.*

134. Here, as before, we examine only those respondents who indicated having any out-of-pocket medical expense in the two years prior to filing for bankruptcy.

135. Differences between those with a medical bill reason for filing and those without a medical bill reason for filing are statistically significant (p-value $\leq .05$) for use of both credit cards

equity loans and credit cards to pay medical bills among those who reported medical bills as a reason for filing is of particular importance to our analysis. If an individual pays for medical care with a credit card or home equity loan, then these expenses will not be identified as medical bills in court records. The data presented in Figure 3 thus support a more nuanced and multi-instrument approach to evaluating the effect of medical debt on bankruptcy filings.

We also examined the congruence between medical obligations captured by the court record and survey methods depending on whether respondents listed a medical bill reason for bankruptcy. Respondents who identified this reason for filing for bankruptcy had, on average, twice the difference between survey medical expenses and Schedule F medical debt as those who did not identify medical bills as a reason for filing.[136] And, as noted in the introduction, over one quarter (27%) of those who identified a medical bill reason for bankruptcy had zero Schedule F medical debt, rendering them invisible in the court record method.

To explore further the possible explanations for reduced or invisible medical debt using the court record method, we look at the medical bill management of respondents based on the levels of discrepancy between the two methods of measurement.[137] Appendix B reports all of our results as well as whether the differences are statistically significant using a traditional ANOVA test.[138] Figure 4 shows three important methods of responding to medical bills. It reports these in groups that had increasing amounts of difference between the court record and survey methods. If paying off medical bills in full were the explanation for the decline or disappearance of medical bills by the time of bankruptcy, we would expect to see high rates of reporting use of cash and cash equivalents by

---

and home equity loans. All differences, when tested across the three groups—1) all respondents with medical expenses, 2) those with a medical bill reason for filing, and 3) those without a medical bill reason for filing—are statistically significant with an ANOVA test. However, we cannot identify which of the differences are causing that statistical significance. ANOVA is an "ANalysis Of VAriance" test, which compares group means by analyzing comparisons of variance estimates to determine whether the differences in means are statistically significant.

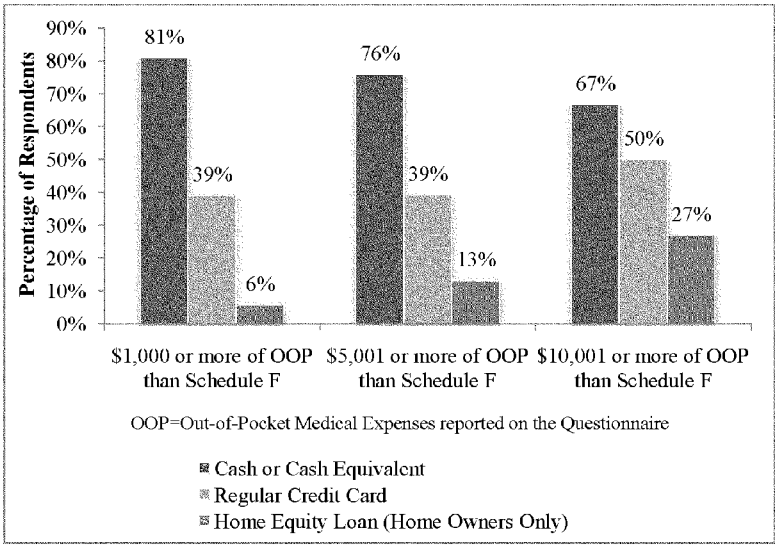
136. The difference is statistically significant. Overall, all respondents reported just over half of a category more of medical expense than of Schedule F medical debt. Those who listed medical bills as a reason for filing had, on average, approximately three-quarters of a category more of medical expense than Schedule F medical debt. Those who did not indicate medical bills as a reason for filing had less than 0.4 of a category more medical expense than Schedule F medical debt.

137. *See supra* text accompanying notes 118-122.

138. As these variables are coded as "Yes" or "No" variables, the frequency can be essentially understood as the percent of respondents in the group replying affirmatively to the question.

respondents with the biggest gaps. Figure 4 and Appendix B show a pattern of slightly decreasing use of cash, with the lowest frequency of cash usage reported by those who reported over $10,000 of medical expenses on the questionnaire but had no Schedule F medical debt.[139] The pattern in Figure 4 suggests that having lower Schedule F medical debt is not due to individuals paying off medical bills completely with cash, debit cards, or checks before filing for bankruptcy.

FIGURE 4: USE OF CASH, CREDIT CARDS, AND HOME EQUITY LOANS FOR MEDICAL BILLS, BY GAP IN MEASURES



By contrast, Figure 4 illustrates a positive relationship between the reported use of a regular credit card to pay medical bills and the difference between the reported expenses on the questionnaire and Schedule F medical debt.[140] This is

139. The difference in use of cash, debit cards, and checks is statistically significant to the 0.002 level. Using the ANOVA method of testing the differences in the groups does not allow us to identify *which* differences are statistically significant, but does allow us to demonstrate that the overall patterns of use vary enough to be statistically significant.

140. The differences in use of a regular credit card for medical bills are statistically significant

consistent with the concern that debts transferred to credit cards become minimized or invisible in court record studies.[141]

Filers with significantly greater out-of-pocket expenses than Schedule F medical debt also indicated use of home equity loans with much greater frequency.[142] This is especially true for those with at least $10,001 more in expenses than Schedule F medical debt; over a quarter of this group used home equity loans to pay medical debts. This is in sharp contrast to the overall rate of 5.8% who used a home equity loan to pay off medical debt among all homeowners in the 2007 CBP.

Appendix C displays the comparative medical bill management for the group of respondents with more than $10,000 in expenses reported on the questionnaire and zero Schedule F medical debt. Members of this small group would have had to expend significant effort to pay off $10,000—or much more—completely in cash before bankruptcy. Also, this biggest of possible differences between the measures would be less likely to be due to forgetfulness about medical bills, partial payoff of medical bills, seeking to hide their bankruptcy cases from providers, or other such explanations. Respondents in this group reported using home equity loans for medical bills at over four times the frequency of everyone else; they also reported using credit cards twice as often as everyone else.

---

to the <0.001 level. Like anyone reporting medical expense on the questionnaire, the group that reported over $10,000 of debt on Schedule F and zero expense on the questionnaire would have skipped the question about managing out-of-pocket expense and thus had the "lowest" use of all methods of payment.

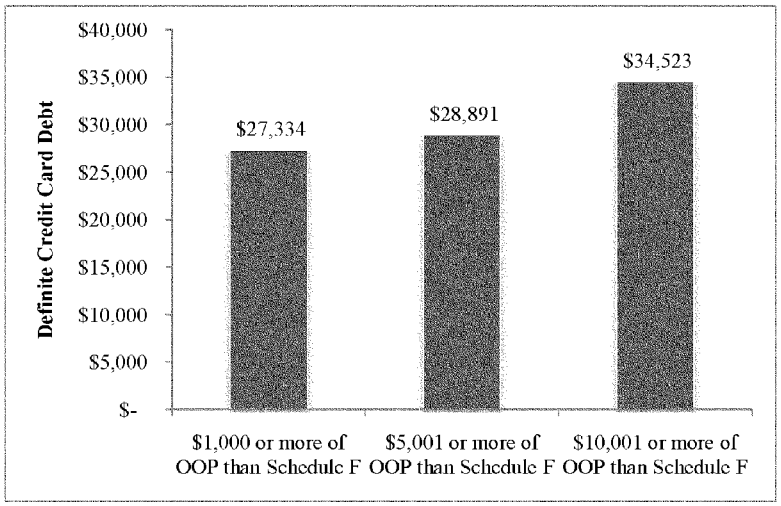
141. As another measure, when we isolated and compared the Schedule F medical debt of those who indicated using credit cards for medical bills from those who did not so indicate, the credit card users reported lower average and median medical debts. However, credit card users had nearly twice the amount of credit card debt. Credit card users had $5,264 average Schedule F medical debt versus $6,841 for non-credit card users. We also compared medians: those who used credit cards to pay medical bills had a median Schedule F medical debt of $1,473, compared to $1,791 for those who did not use a credit card. The difference is significant to the 0.05 level. Those who reported using a regular credit card to pay for medical expenses filed, on average, $31,853 in credit card debt on Schedule F, compared to $15,792 in credit card debt for those who did not use a regular credit card to pay medical expenses.

142. Figure 4 portrays the percentages of those who owned a home and used a home equity loan for medical expenses; if we look at all filers, (i.e. not just those who owned a home in the last five years) we see a similar pattern, but smaller numbers. For example, 19% of those in the highest group report using a home equity loan, compared to 3% of those reporting the same amount on both measures. The differences exhibited using either methods of measurement are statistically significant to the 0.0001 level. All data on the individual breakdown of use of home equity loans are available in Appendix B.

Generally, filers with the greatest amounts of out-of-pocket expenses but zero Schedule F medical debt had a much higher rate of reporting that they shifted obligations to alternate creditors that are undetectable as medical on court records.

To further corroborate these findings, we looked at the amount reported on Schedule F of claims owed to *credit card* lenders (as opposed to claim holders with medical identities).[143] Figure 5 reports the results.

FIGURE 5: AVERAGE SCHEDULE F CREDIT CARD DEBT, BY GAP IN MEASURES



As Figure 5 shows (and is reported more fully in Appendix D) the amount of Schedule F credit card debt grows as the gap increases between the survey and court record methods of identifying medical obligation.[144] The filers represented

143. It can be difficult to identify credit card debt because of the variety of ways debt can be listed on Schedule F. Although we would get the same results either way as the next footnote explains, we used a very conservative, lower bound definition of credit card debt by using only debt in which the listing contained the words "credit card," "card," "revolving credit," "charge account," or closely similar terms. Also, any listing that contained brand name words for a credit card, such as "Visa," "MasterCard," or "Discover," was counted as *definitely* credit card debt.

144. This result is obtained with the "definitely credit card" variable, but the same pattern

in Figure 5—the fifth of the sample with verifiably higher out-of-pocket expenses than Schedule F medical debt—had much greater average credit card debts than the $19,006 average credit card debt of all filers in the sample, and also had higher median credit card debts than the median of the overall sample. Again, this suggests that those with less Schedule F medical debt are not necessarily paying off medical debt with ease, but rather are shifting medical bills to alternate forms of credit.[145] These findings also support the story that bankruptcy filers in our sample made their medical providers a higher priority than other types of creditors. As money is fungible, these individuals went into bankruptcy with lower medical debt but higher levels of credit card debt.[146] In addition to the court record information on credit card usage, we find a parallel trend regarding home mortgages. As the gap grows between the questionnaire medical expenses and Schedule F medical debt, so do the amounts of secured claims against filers' residences.[147] This generally corroborates filers' reporting of home equity use for medical bills.

We explored other indicators that might shed light on why medical expenses are not appearing on Schedule F. The 2007 CBP questionnaire asked respondents to indicate whether they engaged in a variety of methods to "make ends meet" during the previous two years.[148] We were interested in whether respondents with

---

emerged when we conducted the same analysis with the "probably credit card" variable, as well as with the two measures combined.

145. The pattern is the same for both chapter 7 and chapter 13 cases, but the amounts in chapter 7 cases are higher for cases fitting the two left-most columns on Figure 5.

146. These results are consistent with an earlier analysis of no-asset chapter 7 cases by researchers at the Executive Office for United States Trustees (in DOJ), in which Schedule F credit card debt levels were particularly high among filers with no observable medical debt on Schedule F. *See* Ed Flynn & Gordon Bermant, *Credit Card Debt in Chapter 7 Cases*, AM. BANKR. INST. J., Dec. 2003/Jan. 2004, at 20 (credit card debt of those with no Schedule F medical debt was higher than those with Schedule F medical debt and "was more than twice as high as for debtors who listed at least $5,000 in medical debt"); *see also* MICHELLE M. DOTY ET AL., SEEING RED: THE GROWING BURDEN OF MEDICAL BILLS AND DEBT FACED BY U.S. FAMILIES (Commonwealth Fund Issue Brief, 2008), *available at* http://www.commonwealthfund.org/Content/Publications/Issue-Briefs/2008/Aug/Seeing-Red--The-Growing-Burden-of-Medical-Bills-and-Debt-Faced-by-U-S--Families.aspx.

147. Home owners with the highest level of difference between medical expenses and Schedule F medical debt (i.e. at least $10,001 more in medical expenses than Schedule F medical debt) also have the highest level of secured claims against their residences, a dollar figure which declines as the difference between medical expenses and Schedule F medical debt decreases..

148. The questionnaire asked: "During the TWO years before the bankruptcy, did EITHER you or a spouse or partner DO, or TRY TO DO, any of the following things in order to make ends

increasingly greater questionnaire-reported expenses than Schedule F medical debt were more likely to report "Consolidated debts with a credit card or new loan" or "Put necessities on the credit card (for example, food or monthly bills)" as coping options. As Appendix E shows, those with higher expenses than Schedule F medical debt were more likely to say that they put necessities on the credit card.[149]

Finally, we turn back to filers' stated reasons for bankruptcy, which in Figure 6 are broken down based on the size of the difference between the court record and survey measures of expenses. This helps determine the consequences of relying exclusively on the court record method to measure medical-related financial burden. As Figure 6 shows and Appendix F reports more fully, as the gap between the court record and survey measures grows, so does the percentage of respondents who indicated medical bills as a reason for filing for bankruptcy (the left-most column in each grouping). These findings suggest that the court record method particularly under-represents medical bill problems for filers who reported medical reasons for filing for bankruptcy.

meet? (Check all that apply.)" Possible responses were: "Worked more hours or got another job; Cashed out or borrowed from a retirement, a 401k, a pension account or life insurance; Refinanced your home, took out a home equity loan or line of credit, or took out a debt consolidation loan that was secured by your home; Sold your house; Asked creditors, such as landlords or credit card companies, to work with you on the payments; Sold or pawned a car, furniture, or other personal property; Consolidated debts with a credit card or new loan; Used a payday loan business (for example, Check to Cash) or car title lender to borrow money or take a cash advance; Put necessities on the credit card (for example, food or monthly bills); Accepted or borrowed money from family or friends; Accepted or borrowed money from a religious group or charity; or Something else."

149. They were not more likely to say that they consolidated debt on a credit card or new loan, but it is not obvious that respondents would conceptualize moving medical bills to credit cards as a consolidation.

FIGURE 6: MEDICAL-RELATED REASONS FOR FILING FOR BANKRUPTCY, BY GAP IN MEASURES

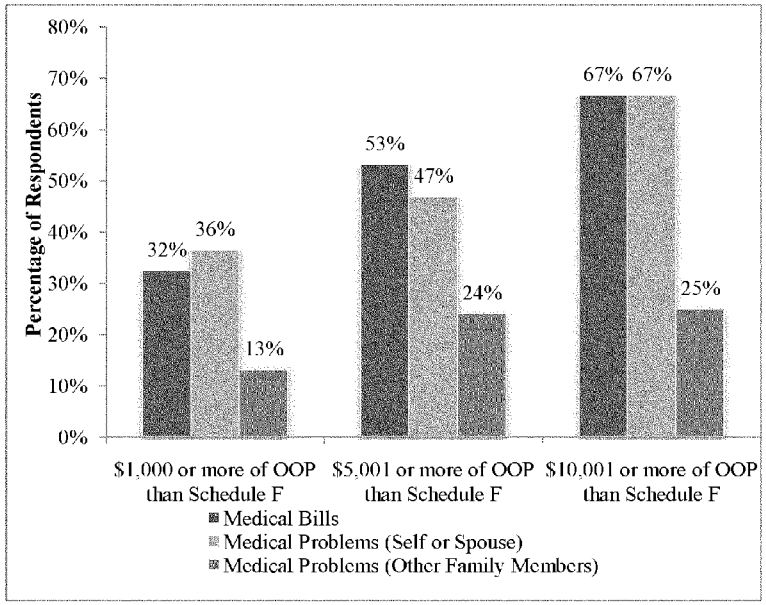


Figure 6 presents the distribution of individuals who said that medical bills, medical problems of self or spouse, or medical problems of other family members were a reason for filing. Again, this distribution is categorized by the difference between the medical expenses reported on the questionnaire and the amount of medical debt reported on Schedule F. Note that two-thirds of respondents with more than $10,000 in medical expenses on the questionnaire and zero medical debt on Schedule F reported that medical bills were a reason for filing for bankruptcy. Thus, Figure 6, like Figure 3, shows that those most affected by medical debt are less likely to show up in a court records study.[150] Had we conducted our study relying entirely on court records as the DOJ did in 2005, our medical debt count would not have included a single member of this

150. While the number of cases that fall into the category of $10,000 or more expenses reported on the survey and zero Schedule F medical debt is small (19 cases in our sample), this group represents a very conservative method of analyzing medical debt in bankruptcy.

group.[151] For the other respondents represented on Figure 6, a study relying exclusively on the court record method would have significantly understated their medical burden.

The analysis for this project has limits. First, as noted earlier, any attempt to code medical debts from court records risks the omission of providers or related parties with no obvious health care designation in its name; our study is no exception.[152] This limit is consistent with our conclusion that multi-instrument studies are preferable to exclusive reliance on court records for some kinds of research questions. Second, the questionnaire did not ask respondents to identify the precise type of health care that they received, precluding a correlation of type of care and medical bill management for the full sample.[153] Third, the nature of the data collection ultimately required that we compare a continuous variable (Schedule F medical debt) with a categorical one (pre-bankruptcy out-of-pocket expenses) based on dollar ranges. The categories are the most precise measures available for out-of-pocket estimates for the full dataset. Fourth, the variables are drawn considerably from self-reported questionnaire data and thus face the same challenges as other interview and questionnaire studies.[154] But to emphasize, this limit applies to the court records as well. This is not a situation in which a debtor

151. The same pattern holds for illness of self or partner as a reason for filing. Familial medical problems were noted as a cause of bankruptcy by a smaller group of filers, but show similar patterns: 25% of the group with the biggest gap between medical expenses and Schedule F medical debt selected familial medical problems as a reason for bankruptcy, compared to 10.7% of the sample population. A full breakdown of the distribution into these categories is available in Appendix F.

152. For example, CSI Financial Services "takes over" a patient's account and offers extended payment plans, but the hospital takes back the debts upon a patient's default on a payment plan. Haugh, *supra* note 18, at 18. Neither CSI Financial Services nor the banks doing the interim financing would be detected as medical on Schedule F under most coding protocols. Some bulk medical debt buyers do not have medical-sounding names. *See generally In re* Andrews, 394 B.R. 384 (Bankr. E.D.N.C. 2008) (discussing bulk buyers in a different context).

153. Diagnosis information was collected via telephone interview and thus is available only for the subset of respondents who participated in that portion of the study.

154. Those who conduct research relying on interview and questionnaire data have long struggled with two principal issues. First, the nature of human response introduces a higher degree of error into the data. *See* John Bound, Charles Brown & Nancy Mathiowetz, *Measurement Error in Survey Data*, *in* HANDBOOK OF ECONOMETRICS 3705 (2001). Second, asking questions about finances and health, two private topics, might introduce additional error. *See* Marianne Bertrand & Sendhil Mullainathan, *Do People Mean What They Say? Implications for Subjective Survey Data*, 91 AM. ECON. REV. 67, 68 (2001). In the context of our analysis, however, we believe that our findings contribute meaningfully to our understanding of an otherwise unexplained discrepancy.

says one thing while a court or creditor says another; in many consumer bankruptcy cases, nearly all of the documents in the court records are submitted by the debtor. Fifth, this study is designed to analyze bankruptcy filers. This means that we cannot directly comment on how non-filers deal with their medical bills.[155] Sixth, we compare court records and questionnaire data for a sample that was drawn in 2007, whereas the DOJ sample was collected in the early 2000s.[156] We cannot prove, of course, that a survey conducted in the early 2000s on the sample captured by the DOJ would replicate our results. But, as Table 1 illustrates, our Schedule F data and the DOJ data (reported in Table 1) are similarly patterned.

We also should take care to note some significant demographic patterns in expense and medical bill management that affect the accuracy of relying only on court records.[157] For example, homeowners and non-homeowners had equal frequency of identifiable Schedule F medical debt, as well as similar distributions across the dollar ranges of Schedule F medical debt.[158] But on the questionnaire, homeowners were more likely to report incurring expenses within the two years prior to filing (81% versus 73%) and had a different distribution of expenses than non-homeowners. Homeowners also were more likely to report using credit cards—and, of course, home equity loans—for medical bills than non-

155. We see glimpses of a difference between the bankruptcy population and the general population. For example, in the tracking survey of the Center for Studying Health System Change, more than half of respondents who reported problems paying medical bills said that providers suggested that they undertake payment plans. CUNNINGHAM, *supra* note 28, at 3. Even among bankruptcy filers who identified medical bills as a reason for bankruptcy, only about a third reported being in payment plans directly with their providers; it is possible that providers suggested plans to more of them. We will discuss provider payment plans in more depth in a separate paper.

156. *See supra* p. 265, tbl.1. Medical costs rose at a rate outpacing inflation generally in the 2000s, and self-pay obligation did as well. Although our literature review focuses largely on more recent publications, we do not believe that medical practice management advice was qualitatively different in the first half of the decade. *See* Jacoby & Warren, *supra* note 33. We do not know of a theory on which the enactment of the 2005 bankruptcy amendments would affect our results.

157. We found few statistically significant differences in the average amount of Schedule F medical debt among those with differing education levels, gender, race, or living arrangements. We also tested for a variety of demographic differences in medical bill management—for instance, age, race, gender, homeownership, and marital status—and again many were not significant. For example, we did not find a significant difference in bill management between respondents who indicated that they lived with a permanent partner and those who lived alone.

158. The homeownership variable includes everyone who reported owning a home within five years prior to filing.

homeowners.[159] A stand-alone analysis of the court records would blunt these differences.

We encountered a similar phenomenon regarding medical expenses among petitioners who identified as African American versus petitioners who identified as white.[160] In our sample, there was not a statistically significant difference between African American petitioners and white petitioners in the frequency or average amount of Schedule F medical debt.[161] But on the questionnaire, African American petitioners reported lower levels of out-of-pocket medical expenses than most other petitioners, and African American petitioners with medical expenses were much less likely to use credit cards or home equity loans (but just as likely to use cash) for the bills they did incur.[162] African American petitioners

159. Nearly three out of ten (27.9%) of those petitioners who owned a home in the five years prior to bankruptcy reported using a regular credit card to pay their medical bills, compared to 17 % of those who did not own a home. As previously noted, 5.8% of homeowners used a home equity loan to pay medical bills. Strangely, 1.2% of filers who said they did not own a home at any time in the prior five years selected this option on the questionnaire. It is possible that the language of the selection led them to believe that this option included lines of credit not secured by homes. Or, they may have used someone else's home as collateral. In any event, this difference, like the difference in credit card usage, is statistically significant to the <0.001 level.

160. The written questionnaire asked respondents to indicate the group with which they identified, with the options of "African American or Black, Asian American, Hispanic or Latino/a, White or Caucasian, Other (please specify), or none." The questionnaire asked for the same information about partners of respondents. For the comparisons, we included in our measure African American respondents who reported no partner (57%) or identified his or her partner as African American (31%), which is the great majority of the respondents who identified as African American.

161. Among households with African American petitioners, 49.4% listed medical debt on Schedule F, compared to 52.6% of white filers. Households with African American petitioners listed smaller average medical debt ($5,688 per household) than did white filers ($6,513). But both of these differences are outside the standard levels for statistical significance. Households with African American petitioners, however, had a lower median Schedule F medical debt ($1,349) than white petitioners ($1,746), and this difference is significant to the 0.05 level. The DOJ report used averages, not medians, and thus would not have captured this difference.

162. 76% of African American respondents reported using cash to pay medical bills, versus 77% percent of white respondents, a difference that is not statistically significant. African American petitioners with medical expense were much less likely than white petitioners to report using a credit card to pay medical bills (11.3% versus 30.1%). This difference persists when we examine the use of home equity loans to pay off medical expense (1.7% versus 5.3%), and when we focus on only those who owned homes some time within the five years prior to filing (2.2% versus 6.9%). The difference in credit card and home equity loan use (including either measurement) is significant to the <0.001 level.

also had significantly less general credit card debt in their court files than other respondents. Looking at the patterns across the distribution of both measures of medical burden, it appears that African American petitioners in our sample were less likely than white petitioners to have reduced or eliminated medical bills owed directly to providers by the time they got to bankruptcy. We cannot control for the variables that might be driving this finding, such as differences in access to medical care and credit.[163] Whatever the explanation, Schedule F and the court record method are somewhat more (though not perfectly) reflective of the pre-bankruptcy burdens of African American respondents in this sample than they are of the pre-bankruptcy burdens of white filers.

A final example comes from the small group of youngest filers: households with at least one petitioner under twenty-five. The youngest filers reported having Schedule F medical debt with much greater frequency than any other age group or all other age groups combined. In addition, on average, households in which at least one of the filers was under twenty-five had an average medical debt on Schedule F of $13,263, compared to an average of $5,846 for all other age groups.[164] Yet, relying on this finding alone would overstate young filers' relative likelihood of having out-of-pocket medical expenses in the two years prior to filing, and may speak instead to their lack of financing options. These filers were less likely than other households to report using a regular credit card for medical bills and had less general credit card debt in their files overall.[165] They were also more likely to report using a provider payment plan or doing

163. As noted earlier, we tested for a variety of other differences based on race and sex relating to medical bills and medical bill management, and they were not significant. According to one prior study, African American families are three times as likely as white families to file for bankruptcy, but their reasons for filing are similar. *See* Elizabeth Warren, *The Economics of Race: When Making It to the Middle Isn't Enough*, 61 WASH. & LEE L. REV. 1777, 1779 (2004).

164. Although the youngest filers had a much higher average Schedule F medical debt than everyone else, the difference between the medians ($1,672 for the youngest versus $1,590 for the older filers) is not statistically significant, suggesting that a small number of the youngest filers with huge Schedule F medical debts skews the average. We see a glimpse of this in Figure 1, where three out of the six filers with Schedule F medical debts over $100,000 were under the age of twenty-five. On a filer-by-filer basis, the very youngest respondents were also much more likely to have the same category of medical expense on both measures than everyone else (46% versus 36%).

165. Among households in which either petitioner was under twenty-five years old, 18.9% reported using credit cards for medical bills, compared to 24% of all other petitioners. This difference is not statistically significant. These youngest filers also had a lower frequency of home equity loan use for medical bills (2.1% versus 4.2% for all other petitioners), but this difference is outside traditional levels for statistical significance.

"something else" about a medical bill, which often meant waiting to discharge the bill in bankruptcy.[166] Both of these latter options increase the likelihood of a pre-bankruptcy medical bill showing up as Schedule F medical debt. Likewise, a much greater proportion of bankrupt households with younger women petitioners (34 and younger) retained direct obligation that appeared as Schedule F medical debt than other groups. But such households were less likely to use a regular credit card or a home equity loan for medical bills and much more likely than others to use a provider payment plan or "something else" as compared to other households.[167]

These demographic observations warrant further study with additional controls. But this preliminary look reveals another layer of complexity that seems to be disregarded by those who rely exclusively on court records to measure medical debt burden.

IV. DISCUSSION

This Article is the first to demonstrate through detailed systematic analysis that the DOJ's court record method, standing alone, is an unreliable measure of the financial burden of illness or injury faced by bankruptcy filers. In our nationally-representative sample of filers, the court record method produced a skewed undercount of medical bills and failed to account for filers with significant medical hardship who had no debt on Schedule F that could be identified as medical. The shifting of medical obligations to creditors with non-medical identities played a large role in the discrepancy between court record and survey information, particularly for respondents with the largest verifiable gaps in measures. Absent changes to the forms on which information about debts is collected, the DOJ court record methodology should not be used to measure the financial burden of health care on bankrupt families.

The demographic assessment suggests that court records better reflect medical bills for some groups of filers than for others. Yet court records, standing alone, are not well-suited to distinguish these filers on the relevant demographic

166. Petitioners under twenty-five years of age with out-of-pocket expense reported provider payment plans 27.4% of the time, compared to all other petitioners, who reported payment plans 22.8% of the time. 21% of the younger petitioners reported doing "something else" to handle expenses, compared to 9.5% of all other petitioners. Both of these differences are statistically significant to the 0.005 level.

167. Looking at the use of credit, the difference between the groups is significant to the <0.001 level using a standard ANOVA test. The difference in use of "something else" is also statistically significant to the <0.001 level, while the difference in the use of cash is too small to be statistically significant.

criteria such as age and racial identity. Furthermore, lawmakers and scholars who have been relying on the DOJ court record study have made no public efforts to draw such distinctions.

The clock cannot be turned back to 2005, when the DOJ analysis enabled lawmakers to vote with a clearer conscience in favor of the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 and against amendments that members of Congress proposed to protect people with medical problems from certain harsher effects of the bill.[168] However, our study should guide the use and interpretation of these kinds of studies in other contexts.

In combination with other methods, the court record method has unappreciated utility to shed light on the impact of patients' bankruptcies on *providers*. Consistent with the medical practice advice reviewed in Part II, health care consultants are concerned that "the last bill people pay is often their healthcare debt."[169] One might have thought that families headed to bankruptcy court would overwhelmingly defer dealing with their medical bills. However, in our national sample, due to filers' payment and credit activities between the time of treatment and the time of bankruptcy, fewer bankruptcy filings directly affected medical providers, and for substantially smaller amounts. Nearly 80% of bankruptcy filers had received medical services or goods resulting in some self-pay obligation within two years before they filed for bankruptcy—while many already were struggling financially. And yet despite their financial hardship, a third of filers with medical obligation had managed to protect their providers entirely from the bankruptcy process, and many others reduced the dollar amount of the obligation.[170] Some filers who reported the largest possible out-of-pocket

168. *See, e.g.*, Melissa B. Jacoby, *Bankruptcy Reform and the Cost of Sickness: Exploring the Intersections*, 71 MO. L. REV. 903, 908 n.21 (2006) (reviewing failed medical-related amendments to the 2005 Act). We recognize that the legislation as a whole had been pending in various forms since 1997, and lawmakers across the political spectrum were evidently responsive to credit industry pressure to enact it. *See generally* Melissa B. Jacoby, *Negotiating Bankruptcy Legislation Through the News Media*, 41 HOUS. L. REV. 1091, 1118 (2004).

169. Robert Czerwinksi & Peter M. Friend, *Selling Written-Off A/R*, HEALTHCARE FIN. MGMT., Sept. 2008, at 128, 130; *see also A New World of Health Care: More Patients Seek Help with Bills*, HEALTH CARE COLLECTOR (Aspen Publishers, New York, N.Y.), Nov. 2008, at 1 (citing an industry expert saying, "As everyone knows, we are often the last bill people pay. I thought it was telling this past month when we heard people say they had to buy books, pay school fees, or pay for their kids' participation in sports so they could not pay the hospitals. Why? Other folks won't let you in without paying, but hospitals will.").

170. In theory, preferential transfer law polices eve-of-bankruptcy payoffs of creditors, including medical providers. *See, e.g.*, 11 U.S.C. § 547 (2006); Cruse v. Hannibal Health Care Sys. (*In re* Watkins), 325 B.R. 277 (Bankr. E.D. Mo. 2005) (applying preference law and ruling for

expenses within the two years prior to filing had no medical providers as creditors in the court records. Schedule F also includes debt older than two years, which increases the debt captured by the court record method. This suggests that our study is a fairly conservative measure of providers' reduction of exposure to their patients' bankruptcies within the two years prior to filing. Thus, a better way to use the court record method is combined with other sources to reveal the extent to which medical providers extricate themselves from the process and consequences of patients' bankruptcies.

V. CONCLUSION

Regardless of whether they are insured, nearly all patients have direct monetary dealings with their medical providers. A body of advice and technological tools help providers manage risks associated with this financial exposure. The advice and tools encourage the use of third-party credit. Our study demonstrates how these practices affect the empirical study of medical burden on patients. In our sample, an exclusively court record study does not merely produce a more conservative measure of medical burden; it hides or diminishes cases in which medical bills were particularly significant.

The health care finance debate intensified the interest in medical bills among financially distressed families such as those found in the bankruptcy system, and the interest in this subject will not subside anytime soon. Our study urges caution in using the DOJ court record analysis or other such studies to measure patient medical debt on a standalone basis. It also casts doubt on efforts to refute survey studies based on court documents alone. Absent changes to the forms on which filers report their debts, or, perhaps, substantial changes in medical bill

---

trustee to recover execution on bond for payment of medical bills subject to state court judgment). Although the law is not uniform, some courts find that a creditor is vulnerable to preference attack even if the debtor simply substitutes another creditor (for example, a credit card or credit card convenience check) to pay the antecedent debt. *See, e.g.*, *In re* Marshall, 550 F.3d 1251 (10th Cir. 2008); *In re* Wells, 382 B.R. 355 (6th Cir. BAP 2008); Flatau v. Walman Optical Co. (*In re* Werner), 365 B.R. 283 (Bankr. M.D. Ga. 2007). But for a variety of legal and practical reasons, preference law is unlikely to have an effect on medical bill payment pre-filing in most consumer bankruptcy cases. First, the preference period is relatively short (ninety days, as mentioned) unless the beneficiary is an insider. 11 U.S.C. § 547(b)(4) (2006) (setting 90-day preference period generally and one year look-back period for insiders). Second, recipients of transfers of value less than $600 have an absolute statutory defense to preference actions in consumer bankruptcy cases, and thus case trustees would not pursue such cases. § 547(c)(8). Third, providers have a defense if they accepted payment in the ordinary course of business, which Congress in 2005 defined broadly to protect more payment recipients. § 547(c)(2).

management, court records alone reveal very little about the burden of medical bills on financially distressed families. At best, when used in combination with other instruments, such records help to shed light on the impact of patient bankruptcy on health care providers—an important but distinct matter.

APPENDIX A: DISTRIBUTION OF DIFFERENCE BETWEEN QUESTIONNAIRE-REPORTED OUT-OF-POCKET EXPENSES AND SCHEDULE F MEDICAL DEBT

	Number	Percent
Four categories more on Schedule F than on the questionnaire (-4)	19	0.78
Three categories more on Schedule F than on the questionnaire (-3)	26	1.07
Two categories more on Schedule F than on the questionnaire (-2)	96	3.93
One categories more on Schedule F than on the questionnaire (-1)	224	9.18
Same category of medical debt on Schedule F and the questionnaire (0)	834	34.18
One category more on the questionnaire than on Schedule F (+1)	584	23.93
Two categories more on the questionnaire than on Schedule F (+2)	373	15.29
Three categories more on questionnaire than on Schedule F (+3)	79	3.24
Four categories more on the questionnaire than on Schedule F (+4)	36	1.48
Missing either questionnaire or Schedule F data (excluded from analysis)	169	6.93
Total	2440	100

APPENDIX B: MEDICAL BILL MANAGEMENT, BY GAP IN MEASURES

	Pay with cash, check, or debit card	Pay with a regular credit card	Pay with a medical credit card	Agree to a payment plan with the medical provider	Some-thing else	Pay with money from a home equity loan or other line of credit	Pay with money from a home equity loan or other line of credit (Home owners only)
	Percent (SD)	Percent (SD)	Percent (SD)	Percent (SD)	Percent (SD)	Percent (SD)	Percent (SD)
-4	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)
-3	87.5% (0.342)	12.5% (0.342)	0.0% (0)	12.5% (0.342)	12.5% (0.342)	6.3% (0.25)	7.7% (0.277)
-2	90.4% (0.298)	13.5% (0.345)	1.9% (0.139)	26.9% (0.448)	7.7% (0.269)	1.9% (0.139)	2.9% (0.171)
-1	78.5% (0.412)	11.4% (0.319)	2.7% (0.162)	28.2% (0.452)	12.8% (0.335)	2.0% (0.141)	3.1% (0.175)
0	73.6% (0.441)	19.3% (0.395)	1.4% (0.119)	31.7% (0.466)	13.8% (0.345)	3.0% (0.172)	4.2% (0.200)
+1	82.5% (0.380)	25.2% (0.434)	2.6% (0.158)	19.7% (0.398)	9.1% (0.288)	4.8% (0.214)	5.8% (0.234)
+2	81.0% (0.393)	39.1% (0.489)	4.3% (0.203)	23.6% (0.425)	7.8% (0.268)	4.6% (0.209)	5.7% (0.232)
+3	76.0% (0.430)	39.2% (0.491)	3.8% (0.192)	27.8% (0.451)	12.7% (0.334)	10.1% (0.303)	13.1% (0.340)

+4	66.7% (0.478)	50.0% (0.507)	0.0% (0)	22.2% (0.422)	19.4% (0.401)	19.4% (0.401)	26.9% (0.452)
Total	79.0% (0.407)	26.0% (0.438)	2.6% (0.159)	25.1% (0.434)	10.8% (0.310)	4.5% (0.207)	5.9% (0.236)
Prob > F	0.0020	0.0000	0.2612	0.0013	0.0465	0.0001	0.0001

APPENDIX C: MEDICAL BILL MANAGEMENT OF THOSE WHO REPORTED MORE THAN $10,000 IN QUESTIONNAIRE MEDICAL EXPENSES AND ZERO SCHEDULE F MEDICAL DEBT

	Pay with cash, check, or debit card	Pay with a regular credit card	Pay with a medical credit card	Some-thing else	Agree to a payment plan with the medical provider	Pay with money from a home equity loan or other line of credit	Pay with money from a home equity loan or other line of credit (Home owners only)
	Percent	Percent	Percent	Percent	Percent	Percent	Percent
All other respondents (SD)	73% (0.45)	23% (0.42)	2% (0.15)	10% (0.30)	23% (0.42)	4% (0.19)	5% (0.225)
$10,001 more than on Schedule F (SD)	67% (0.48)	50% (0.51)	0% (0.00)	19% (0.40)	22% (0.42)	19% (0.40)	27% (0.452)
Probability > F	0.4218	0.0002	0.000	0.3465	0.9054	0.0029	0.0000

APPENDIX D: DEFINITE CREDIT CARD DEBT REPORTED ON SCHEDULE F, BY GAP IN MEASURES

	Mean (standard deviation)
-4	$15,148.75 (24950.728)
-3	$14,518.50 (25589.335)
-2	$9,754.48 (16860.425)
-1	$13,457.91 (20811.045)
0	$15,075.98 (22072.988)
+1	$19,892.82 (26959.325)
+2	$27,334.37 (34652.081)
+3	$28,890.91 (32613.587)
+4	$34,523.00 (27361.75)
Total	$18,837.03 (27361.75)
Prob > F	0.0000

APPENDIX E: CREDIT CARDS TO MAKE ENDS MEET, BY GAP IN MEASURES

	Put necessities on the credit card (for example, food, or monthly bills)	**Consolidated debts with a credit card or new loan**
	Percent (standard deviation)	Percent (standard deviation)
-4	47.4% (0.513)	36.8% (0.496)
-3	42.3% (0.504)	15.4% (0.368)
-2	40.6% (0.494)	17.7% (0.384)
-1	40.2% (0.491)	25.0% (0.434)
0	52.3% (0.5)	31.4% (0.464)
+1	56.5% (0.496)	37.3% (0.484)
+2	65.7% (0.475)	46.1% (0.499)
+3	64.6% (0.481)	43.0% (0.498)
+4	75.0% (0.439)	47.2% (0.506)
Total	54.5% (0.498)	34.7% (0.476)
Prob > F	0.0000	0.0000

APPENDIX F: MEDICAL REASONS FOR FILING FOR BANKRUPTCY, BY GAP IN MEASURES

	Medical or health care bills, including prescription medications	**Medical problems experienced by you or your spouse or partner**	**Medical problems of other family members (such as children or parents)**
	Percent (standard deviation)	Percent (standard deviation)	Percent (standard deviation)
-4	21.1% (0.419)	26.3% (0.452)	5.3% (0.229)
-3	26.9% (0.452)	30.8% (0.471)	3.8% (0.196)
-2	22.9% (0.423)	29.2% (0.457)	8.3% (0.278)
-1	25.0% (0.434)	28.6% (0.453)	8.9% (0.286)
0	27.9% (0.449)	28.9% (0.454)	9.0% (0.286)
+1	25.2% (0.434)	31.0% (0.463)	10.6% (0.308)
+2	32.4% (0.469)	36.5% (0.482)	13.1% (0.338)
+3	53.2% Z(0.502)	46.8% (0.502)	24.1% (0.43)
+4	66.7% (0.478)	66.7% (0.478)	25.0% (0.439)
Total	28.9% (0.453)	31.9% (0.466)	10.7% (0.31)
Prob > F	0.0000	0.0000	0.0002

Mr. COHEN. Now, thanking everyone for their statements, without objection other Member statements will be put in the opening record—placed in the record.

[The prepared statement of Mr. Johnson follows:]

Congressman Henry C. "Hank" Johnson, Jr.
Statement for the Hearing on

H.R. 901, the "Medical Bankruptcy Fairness Act"
July 15, 2010

Thank you, Mr. Chairman, for holding this hearing on the Medical Bankruptcy Fairness Act.

This hearing will give Members the opportunity to explore whether the Medical Bankruptcy Fairness Act is the tool that should reform the bankruptcy code to respond to the needs of distressed medical debtors.

I applaud the Chairman for holding this hearing and exploring solutions to the overall problem of rising medical debt.

According to the Access Project, in 2007, the most recent year for which data are available, an estimated seventy-two million Americans had medical bill problems.

Many of those Americans made paying off medical bills a top priority and therefore struggled to pay for other basic necessities like food, rent and clothing.

According to that report, more than thirty million American adults used up all their savings or borrowed against their homes in order to pay off medical bills.

This, however, did not stop the bill collector from knocking on their door if they came up short.

According to a June 2009 American Journal of Medicine study, sixty-two percent of all bankruptcies filed in 2007 were linked to medical expenses.

Of those who filed for bankruptcy in 2007, nearly eighty percent had health insurance.

According to that study, most medical debtors were well educated and middle class.

Due to the recent recession and record unemployment, more and more Americans cannot afford health insurance.

Last year, Families USA released a report that showed nearly three million people under the age of sixty-five, in my home state of Georgia, were uninsured at some point in 2007 or 2008.

This session, Congress scored a historic victory in the century-long battle to reform the nation's broken healthcare system.

Passing healthcare reform will definitely improve this situation, but a number of the provisions do not kick in until 2014. Thus, medical debt is a problem that must be adequately addressed.

I hope this hearing will give us all the opportunity to understand the serious consequences that medical debt has on our constituents.

I look forward to hearing the witnesses' views on how Congress can solve this problem.

Thank you Mr. Chairman and I yield back the balance of my time.

Mr. COHEN. I am now pleased to introduce the witnesses and hear their testimony.

First, thank you for all participating in today's hearing. Without objection, your written statements will be placed into the record,

and we would ask you to limit your oral remarks to 5 minutes. We have a lighting system. Green means you have started and you have got 5 or less minutes to go. Yellow means you are in your last minute, and red means you should have finished.

After each witness has presented his or her testimony, Subcommittee Members will be permitted to ask you questions with the same 5-minute limitation.

Our first witness is the Honorable Cecelia G. Morris. Judge Morris was appointed United States bankruptcy judge for the Southern District of New York and took the bench on July 1 of 2000. Prior to appointment to the bench, Judge Morris served as assistant district attorney in the Child Support Recovery Unit of the District Attorney's Office of the Spalding Judicial District headquartered in Griffin, Georgia.

Judge Morris also worked in private practice and served as clerk of the court for the United States Bankruptcy Court for the Southern District of New York from 1988 to 2000, the first bankruptcy court to implement electronic filing of original documents to the court via the Internet.

She is a frequent writer and lecturer on issues related to bankruptcy, published articles on mediation, consumer credit counseling requirement in bankruptcy, and cross border insolvency cases under Chapter 15. She has roots in Texas and Georgia and though she claims now to be a northerner, she is a southerner at heart.

Thank you, Judge Morris. Will you begin your testimony?

TESTIMONY OF THE HONORABLE CECELIA G. MORRIS, UNITED STATES BANKRUPTCY JUDGE, SOUTHERN DISTRICT OF NEW YORK

Judge MORRIS. Thank you, Chairman Cohen and Ranking Member Franks and other distinguished Members of the Subcommittee. Good morning. Thank you for inviting me to testify concerning H.R. 901. I testify today at your invitation. I do not represent any group or organization. The thoughts expressed are mine.

As someone with over 25 years experience in the bankruptcy field and as the former clerk of court for the Southern District of New York and, as has been noted from my accent, the Middle District of Georgia, and now for the past 10 years as a judge in a busy, mostly consumer division of one of the largest consumer courts and commercial courts in the world, the Southern District of New York, I come before you.

You have many sources, including quotes from my written materials about the statistics concerning medical debts and bankruptcy. And I agree that this has been a very interesting discussion, and I have been so pleased to be an eavesdropper on the discussion that you have had amongst yourselves.

I would like to share with you a courtroom observation. Day before yesterday—Tuesday—is my regular hearing day. This is often the first time I see the debtors. They are in court with their attorney, or they come alone. They are in attendance for confirmation of chapter 13 plans, to defend motions to dismiss or motions to lift the automatic stay, and that, of course, is usually so that a foreclosure can proceed.

Many matters are before me on Tuesdays, and because that day has many different types of issues, I begin to know the debtors and their stories. This Tuesday was typical. Tuesdays are long, hard days made harder by the emotional moments revealed during proffers by the lawyers and testimony of the debtors. And this Tuesday was no exception.

A gentleman came to a counsel table with his lawyer. The debtor was vaguely familiar. The lawyer, who often appears in my court, is experienced and one of the best in representing consumer debtors, immediately informed me, as she should, that the debtor was a repeat filer. He had been before me previously, and he was unable to make his Chapter 13 plan payment and to physically attend the first meeting of creditors.

The lawyer knows that while I am a supporter and believe in the bankruptcy system and feel that we—and as Congressman Franks, Ranking Member Franks has suggested—that as citizens of this country we are really blessed with many things, and one of the things that we are blessed with is a debt forgiveness statute.

I lose patience with those, though, who take advantage of our system and do not work with their attorneys and the trustees and the court. So you can imagine how quickly I regained my patience when the lawyer quietly told me that the debtor had now progressed to stage IV cancer. A once robust man, now a shadow of himself, he had been unable to fulfill the requirements of his previous bankruptcy filing.

The lawyer was unaware of the client's battle with cancer. She had prepared his petition. Remember, this is a good lawyer. She had looked at his financial information. She had gone over these bills. Significant medical debt was not apparent in reviewing this information. It was characterized as other debt.

Under H.R. 901 debtors like this gentleman will be able to pass the means test, an important step.

Additionally, under the current bankruptcy code, lenders can be compelled to—can't—excuse me—can't be compelled to agree to loan modifications on the first mortgage for a primary residence. At least in the Southern District of New York, debtors suffering from chronic medical problems, such as this debtor, or caregivers have an opportunity to negotiate to keep their homes.

Using the Civil Justice Reform Act of 1990, the bankruptcy judges of the Southern District of New York adopted a loss mitigation program aimed at bringing debtors and secured creditors together.

The Southern District of New York's loss mitigation program opens communication in two significant ways. First, it requires the lender to disclose direct contact information for a person with full authority to make a decision on a re-mod—re-fi. And second, it provides the lender with protection from the violation of the automatic stay allowing them to speak directly with the debtor.

Who knows what awaits this debtor in my court with stage IV cancer magically? We do know that he needs to stay within the protection of the bankruptcy law, and he needs to have an ability to speak with an accountable human being from the secured lender to make sure he and his family are not disrupted from their home

during a time when he needs to be concentrating his energies on healing. I thank you.

[The prepared statement of Judge Morris follows:]

PREPARED STATEMENT OF THE HONORABLE CECELIA G. MORRIS

Submission of Hon. Cecelia G. Morris to the House Judiciary Committee
July 15, 2010

Frances Fredericks, the courtroom deputy for the Poughkeepsie Division court, always prepares the court for session. One day, as she was turning on the electronic recording equipment, posting the court's agenda, and preparing the bench for the day, people begin to file into the courtroom. She noted five women in turbans. She came back into chambers to let me know that, "it is going to be a tough day." She knew that each of those five women had a story, and each of their stories was going to include something about their individual cancer treatments. The men and women who hobbled in that day were in difficult positions. Most of the stories included the loss of a job due to the inability to work because of the chronic illness or injury. They lost their health insurance. They can't afford gap insurance. They used credit cards to pay bills, they cannot live without their doctors, prescriptions, food or shelter.

It is well documented that around half of all bankruptcies are the result of a serious medical problem.[1] As little as twenty years ago, the aftermath of serious medical problems accounted for less than ten percent of all bankruptcies.[2] There have been a number of changes in the last twenty years including increase in health costs, surging number of un-insured and underinsured Americans, and significant changes to the Bankruptcy Code.[3] This written material seeks to briefly lay out a bankruptcy judge's perspective on the impact of serious medical conditions on bankruptcy, comment on the text of H.R. 901, and demonstrate a connection between H.R. 901 and the Loss Mitigation Program in the Southern District of New York.

There are at least two opposing schools of thought when it comes to the effect of medical debts on bankruptcy filings; that the correlation is overstated, versus serious medical problems are the largest contributing factor to bankruptcy filings. I believe that

---

[1] David U. Himmelstein et al., *Illness and Injury as Contributors to Bankruptcy*, HEALTH AFF. WEB EXCLUSIVE W5-66 exhibit 1 (2005); *See also* Testimony of Prof. Elizabeth Warren before the House Judicial Committee July 17, 2007; *Also* David Himmelstein, Deborah Thorne, Elizabeth Warren and Steffie Woolhandler, *Illness and Injury as Contributors to Bankruptcy*, HEALTH AFFAIRS (February 2, 2005).

[2] Teresa A. Sullivan, Elizabeth Warren, and Jay L. Westbrook, *The Fragile Middle Class: Americans in Debt* (Yale University Press 2000).

[3] David Himmelstein, Deborah Thorne, Elizabeth Warren and Steffie Woolhandler, *Medical Bankruptcy in the United States, 2007: Results of a National Study*, AMERICAN JOURNAL OF MEDICINE (2009).

the effect of serious medical problems on bankruptcy has been understated in academic research largely because medical debt is pervasive and often disguised as other types of debt including credit card debt, mortgage debt, or judicial judgments.[4] My ten years on the bench as a bankruptcy judge in a largely consumer court has shown that debtors will do anything to pay medical bills for themselves, their spouse, children, or member of their household. Their need for care outstrips any financial caution.

The preamble of proposed H.R. 901 states a desire to "provide protection for medical debt homeowners, to restore bankruptcy protections for individuals experiencing economic distress as caregivers ... and to exempt from means testing debtors whose financial problems were caused by serious medical problems." It is my belief that H.R. 901 moves in the right direction to address the devastating impact of serious medical problems, and more needs to be done to alleviate the burden on debtors experiencing such events. An important first step is to exempt medically stressed debtors and caregivers from the means test, which is appropriate considering the Congressional intent behind the means test. The means test was enacted to address perceived abuses in chapter 7 bankruptcies, and was not meant to apply to medically stressed debtors who did not make a choice to go into debt as a result of medical catastrophes.[5]

The Southern District of New York Bankruptcy Court's Loss Mitigation Program has been an illuminating tool in my understanding of the effect of medical problems on bankruptcy. The Loss Mitigation program, which will be explained in greater detail, opens up the lines of communication between debtors and their secured creditors to discuss possible loan modifications. As part of the program, there are numerous and regular status conferences before the Court. Although these status conferences are time consuming, the Court learns an enormous amount of information that was not previously available to the Court. The Court hears why income levels have been reduced (sick spouse) or why they will increase (the death of a child means there is no longer a need for round the clock supervision) and more commonly why the debtor missed so many

---

[4] *See e.g.* Aparna Mathur, Statement before the U.S. House of Representatives Committee on the Judiciary, Subcommittee on Commercial and Administrative Law, "Medical Debt: Is Our Healthcare System Bankrupting America." July 28, 2009.

[5] The Bankruptcy Code has various other tools to address debtor abuse including exception to discharge in 11 U.S.C. § 523, avoidance of fraudulent transfers under 11 U.S.C. § 548, and preference actions under 11 U.S.C. § 547.

months of mortgage payments (lost job due to injury). The program has been invaluable in illuminating the Court's perspective on the day to day needs of debtors.

Effect of Serious Medical Conditions on Bankruptcy

Health care costs are rising exponentially. In about twenty years, annual health care expenditures in the United States rose from $714 billion to over $2.3 trillion.[6] In 2008, health care spending was about $7,681 per resident, which accounted for 16.2% of the gross domestic product.[7] Real median household income has risen slightly in the last twenty years from about $48,000 to $50,303.[8] During the same time period, the number of uninsured individual has risen from 35 million to 46.3 million.[9] How are individuals paying for the increasing burden of medical costs while their income remains stagnant? My experience in the courtroom points to the different solutions employed by debtors in order to shoulder this burden including: spending down bank accounts, using credit cards to pay for medical care or other necessary expenses, emptying out retirement accounts and taking out second and third mortgages on their real property.

A 2008 National Household Survey of credit card debt among low-income and middle-income households showed that income has been stagnant or decreasing while the cost of living expenses increased.[10] A 2007 study showed that 40 percent of all individuals filing for bankruptcy had lost income due to illness and that nearly 35 percent had medical bills in excess of $5,000 per year or at least ten percent of their annual family income.[11]

---

[6] Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, National Health Care Expenditures Data, January 2010.
[7] Anderson, G.F., B.K. Frogner. November 2008, Health Spending in OECD Countries: Obtaining Value per Dollar. *HEALTH AFFAIRS* 27(6):1718-1727; See also http://www.kaiseredu.org.
[8] U.S. Census Bureau, Income, Poverty, and Health Insurance Coverage in the United States: 2008 (September 2009) at 7. http://www.census.gov/prod/2009pubs/p60-236.pdf.
[9] U.S. Census Bureau, Income, Poverty, and Health Insurance Coverage in the United States: 2008 (September 2009) at 29. http://www.census.gov/prod/2009pubs/p60-236.pdf.
[10] Jose Garcia and Tamara Draut, The Plastic Safety Net, How Households are Coping in a Fragile Economy, Demos (July 28, 2009). http://www.demos.org/pubs/psn_7_28_09.pdf.
[11] David Himmelstein, Deborah Thorne, Elizabeth Warren and Steffie Woolhandler, *Medical Bankruptcy in the United States, 2007: Results of a National Study*, AMERICAN JOURNAL OF MEDICINE (2009) at 3.

Submission of Hon. Cecelia G. Morris to the House Judiciary Committee
July 15, 2010

My experience on the bench illuminates this phenomenon. An example that comes to mind is of a debtor whose wife was dying of breast cancer. This debtor was lucky. He was employed with an internationally known firm and had excellent insurance. His wife was no longer able to financially contribute to the household, so the burden was shifted entirely to him. Co-payments and co-insurance stretched his already tight budget. The debtor had to pay his wife's doctor because she needed a continuation of care. First the debtor tapped all the equity in his home to pay for these expenses and then began to makes charges on his credit card to pay for taxi fare to and from the doctor's office, since he could not leave work to take his wife. Apart from the majority of costs that were covered by medical insurance, there were numerous supportive care expenses including hot water bottles, humidifiers and other things not covered by insurance. My experience has shown me that debtors will do anything to ease pain and suffering, especially when the medical care is for a loved one. This includes the use of those very convenient blank checks sent by credit card companies in the mail. Generally, the debtors need cash to pay for at least some expenses and these checks become a double edged sword. After a debtor files for bankruptcy, the credit card companies that issue these checks file adversary proceedings to except the debt from discharge, alleging that the debtors used them fraudulently or under false pretenses.

A quadruple jump in medical costs and stagnant income in the last twenty years has resulted in increased pressure on a growing number of debtors. The vast majority of individuals do everything in their power to pay medical expenses before they contemplate filing for bankruptcy. These individuals do not choose to get sick, injured or have a member of their household develop a serious illness. A countless number before me are debtors who have emptied out exempt retirement accounts, taken out a second mortgage or increased their first mortgage, borrowed from friends and family members, and sold cars or personal property all to pay medical expenses. These individuals find themselves in a situation where they genuinely want to work but cannot because they have a serious medical condition, are paying for a relative with a serious medical condition, or are caring for a household member with a serious medical condition. Often times their work hours are reduced voluntarily or non-voluntarily as a function of their own physical needs or their commitments as caregivers.

Submission of Hon. Cecelia G. Morris to the House Judiciary Committee
July 15, 2010

Medical expenses often do not appear on the bankruptcy petition as medical debt. In the case where a debtor lost income as a result of caregiving functions or a medical condition, the reduced income would appear on the petition without explanation. The same is true of bank and retirement accounts wiped out to pay for medical expenses; the reduced balance would appear on the petition without explanation. The same phenomenon is present for a second mortgage that was taken for the purpose of paying medical expenses.

11 U.S.C. § 707(b)(2), known as the means test, establishes a presumption of abuse for certain chapter 7 debtors. The means test, put into place by the 2005 amendment to the Bankruptcy Code, looks at the debtor's current monthly income and allowable expenses and creates a presumption bad faith when the number is above a certain amount. Under 11 U.S.C. § 707(b)(2)(B)(i) this presumption of abuse can only be rebutted under special circumstances such as a serious medical condition or call to active duty. H.R. 901 would allow economically distressed caregivers and medically distressed debtors to defeat a presumption of abuse.

Analysis of H.R. 901

Under H.R. 901, once a debtor has established that he or she is a medically distressed debtor, they would then qualify for at least two benefits. The property exemptions outlined in 11 U.S.C. § 522 would now include section (r), which would exempt the debtor's aggregate interest up to $250,000 in personal or real property that the debtor or a dependent of the debtor uses as a residence or burial plot. 11 U.S.C. § 522(r) would allow debtors to opt out of less generous state exemptions and opt for the $250,000 exemption. Although this is a very positive development for debtors with significant equity in their property, this level of equity in a residence is increasingly rare. In my example above about the debtor with a wife dying of breast cancer, he attempted to meet her medical needs despite being hopelessly under water each month by tapping the equity in his home. That particular debtor had insurance coverage for his wife, and if she had been un-insured he would have exhausted the equity in his home at a much greater speed. The equity in their residence is generally exhausted before filing for bankruptcy.

Submission of Hon. Cecelia G. Morris to the House Judiciary Committee
July 15, 2010

H.R. 901 also seeks to create a class of debtors who are economically distressed caregivers. These individuals receive a work reduction or loss of work as a result of care for a relative for at least 30 days. Economically distressed caregivers and medically distressed debtors would be immune from motions to dismiss founded on the presumption of abuse under the means test.

There is a practical problem of implementation, namely what type of notification and documentation will the debtor need to provide in order to qualify for this exemption? This creates a privacy issue. Should the Bankruptcy Code require a debtor to put potentially confidential medical information on the Electronic Case Filing System? Section 107 of the Bankruptcy Code states that information filed in a bankruptcy are "public records and open to examination by any entity at reasonable times without charge." Who would be able to challenge the assertion that the debtor fails to rebut the presumption that the debtor filed in bad faith? Would those entities then be entitled to review the medical documentation?

Loss Mitigation Program

The status conferences of the Loss Mitigation Program are a window for the Court to see what causes debtors to file for bankruptcy. The Loss Mitigation Program went into effect January 5, 2009, in the Bankruptcy Court for the Southern District of New York, which has jurisdiction over New York, Bronx, Westchester, Rockland, Orange, Dutchess, Ulster and Sullivan counties, and concurrent jurisdiction over Greene and Columbia counties in New York. Loss Mitigation must be requested by the debtor or the creditor and is not mandatory upon the filing of a bankruptcy case.

Although lenders cannot be compelled to agree to loan modifications and bankruptcy judges are barred from modifying first mortgage on primary residences, lenders can be required to enter into discussions with borrowers. When foreclosure proceedings are under way in state court, some homeowners seek bankruptcy protection. The United States Bankruptcy Code allows homeowners to propose their own plan for repaying missed mortgage payments over as long as a five-year period, while paying current mortgage payments as they come due. The amounts needed each month to rehabilitate a mortgage are too much for some seriously ill homeowners or caregivers to

afford, and as currently drafted, the Bankruptcy Code does not permit debtors to reduce or modify mortgages on real property used as their principal residence as they could for most other types of mortgages and liens. This means that homeowners who don't have the income to catch up on their mortgage will soon find themselves back in foreclosure proceedings, unless they can reach agreement with their lenders. This is when the Loss Mitigation Program is made available to the parties.

The Bankruptcy Court's Loss Mitigation Program opens the lines of communication in two significant ways. First, it requires the lender to disclose direct contact information for a person with full authority to make a decision. Second, it provides that the lenders will not be liable for violating the automatic stay if they participate in loss mitigation discussions with a homeowner in bankruptcy. In other aspects, the Bankruptcy Court's Loss Mitigation Program is similar to court-sponsored mediation programs,[12] which encourages the parties to settle their own disputes where the cost and risks of litigation would be too much for one or both parties to bear. The idea behind the Loss Mitigation Program is a simple one – to identify the decision makers for both the debtor and the lender, to prescribe a period for them to meet and discuss a consensual solution, and to provide a uniform set of guidelines and judicial oversight. Debtors benefit from having an identified contact who has authority to negotiate and bind the lender to the resulting agreement, what information they must supply, and how to submit it and make payments. The regularly scheduled status conferences provide the Court with a dramatic window into the financial life of a debtor over an extended period of time. One particular debtor filed her request for Loss Mitigation on Jan. 20, 2009. After a more than a year of adjournments, loss mitigation was finally terminated on the record of the hearing on April 27, 2010. The debtor's husband was dying of cancer, and the bank couldn't wait anymore. The chapter 13 trustee's motion to dismiss was granted on July 1, 2010, and the case was closed. Debtor remains liable for her credit card debt and is vulnerable to legal action by her creditors.

---

[12] *See* Civil Justice Reform Act, 28 U.S.C. §§ 471-482 (1990).

Submission of Hon. Cecelia G. Morris to the House Judiciary Committee
July 15, 2010

Conclusion

H.R. 901 is a beginning in helping debtors who are financially distressed due to chronic illness or injury to rehabilitate their balance sheets to be able to provide for their loved ones. The Court's Loss Mitigation Program has provided a window into the daily financial lives of debtors with serious medical conditions or those who provide care to loved ones. The situation is more serious than academic research suggests and Congressional action is necessary in order to ease the burden on these well intentioned debtors who are burdened by unforeseen events. The application of the Means Test to medically distressed debtors and caregivers is contrary to Congressional intent to curb perceived abuse, and H.R. 901 corrects this injustice.

Mr. COHEN. Thank you, Judge Morris. I do wonder, and I am not supposed to ask you questions now, when you said somebody was a good lawyer as suggesting that there were something else other than? So anyway, thank you for your testimony.

And our next witness is Dr.——

Judge MORRIS. That is another day.

Mr. COHEN [continuing]. Aparna Mathur—Mathur?

Ms. MATHUR. Mathur.

Mr. COHEN. Mathur.

Dr. Mathur is an economist who writes about taxes and wages. She has been a consultant to the World Bank and has taught economics at the University of Maryland. Her work ranges from research on carbon taxes and the impact of state health insurance mandates on small firms to labor market outcomes. Her research on corporate taxation includes the widely discussed, co-authored 2006 "Taxes and Wages" paper, which explored the link between corporate taxes and manufacturing wages.

She is fortunate to have the parents she has, and genetics proves that intelligence and attractiveness can be passed from one generation to the next.

Dr. Mathur, you are recognized.

TESTIMONY OF APARNA MATHUR, Ph.D., RESIDENT SCHOLAR, AMERICAN ENTERPRISE INSTITUTE

Ms. MATHUR. Chairman Cohen, Mr. Conyers, Ranking Member Franks and distinguished Members, thank you for inviting me to testify here—I am happy to be back—and especially for recognizing my parents. I am sure they are thrilled.

I am going to talk about the Medical Bankruptcy Fairness Act, I am sorry to say that I will not be—you now have two people in this room who do not accept the hypothesis that 60 percent of the filings are due to medical reasons.

The Medical Bankruptcy Fairness Act is intended to institute amendments to the bankruptcy code of 2005 to make the bankruptcy process easier for medical debtors. I am sure all of us would agree that a person who is undergoing a medical crisis needs help more than someone who recklessly spends money on the credit cards.

We all have friends and family who are struggling with illness and death and yet have to deal with hospital and medical bills. However, I would like to caution the Committee about the act, which may be an example of good intentions that could go bad.

My testimony will show how the act could harm exactly the people, the debtors, that you are trying to help. The Medical Bankruptcy Fairness Act focuses on medical debtors, and as is clear to me, the urgency to tackle the issue of medical bankruptcies is being largely justified on the basis of the Himmelstein studies claiming that more than 60 percent of court filings are caused by medical debt.

These statistics are simply not borne out by household surveys carried out by institutions like the Federal Reserve as well as other datasets widely used by academics.

While bankruptcy filings have increased by 25 percent since the start of this decade, medical debts—or even if you think that med-

ical debts are all part of credit card debts—have not changed significantly as a share of total debt over this period, as per the Federal Reserve data.

To put things in perspective, in 2007 only 2.4 percent of families reported any medical debt. In fact, the large economics literature using standard estimation techniques to study the link between medical debt and bankruptcies has found little in back, if any, of medical debts on bankruptcy filings. That seems obvious to me that medical debts could not be a significant factor in rising consumer bankruptcies.

The reason the Himmelstein studies find such a significant impact is because of methodological problems, which I deal with in my longer written testimony.

To take a simple example, it seems to me that the Himmelstein studies by including in medical bankruptcies anyone who missed 2 weeks of work due to illness or anyone reporting any medical problem at all are overstating the problem. We have all experienced illness and taken sick days off from work, sometimes for a week or more, and yet the bankruptcy filing rate for the Nation as a whole is less than 1 percent. So just the fact that in their sample people also reported these problems cannot be taken to imply that these problems caused the bankruptcy.

The point I am making is that if we are misdiagnosing the problem, if we are saying that medical debts are the largest single factor responsible for bankruptcies, when in fact something like involuntary unemployment is, then the solutions we come up with will be equally mis-targeted. We cannot afford to make those mistakes today and divert scarce resources when people need help urgently in other areas like unemployment, which we all know is at a historical high.

Now, to get back to my point about good intentions gone bad, I would like to caution that the act itself may be open to abuse and fraud, even if we believe that we really want to help medically bankrupt people.

The act defines a medically distressed debtor as a debtor who has medical debts in excess of 25 percent of household income or $10,000, whichever is less. So imagine a filer with $70,000 in annual income, which is almost double the average income in the country. If he accumulated $10,000 in medical debts, then he or she can file for medical bankruptcy under Chapter 7.

The problem with this is that a study of bankruptcy filers by income in 2000 to 2002 show that credit card debts averaged approximately $42,000 for this group. While such provisions are unlikely to affect honest debtors, we all know that there are borrowers who behave strategically when faced with such incentives.

In the worst-case scenario, such opportunistic debtors could, by not paying off their medical debt, take advantage of the high exemptions and the debt discharge provisions of Chapter 7 to get rid of their high credit card debts.

Further, removing the means testing requirement from medically distressed debtors and allowing the much higher homestead exemption would simply perpetuate these perverse incentives. Doing away with the means test would allow high-income individuals to

walk away from not only the medical debts, but also all other debts.

Now, the reason we care about this kind of strategic behavior and these unpaid costly debts is that it has implications for medical debtors and other debtors who are caught in a helpless situation.

Study after study has shown that when you make filing for bankruptcy easier through removal of means testing through providing high exemptions, credit markets react adversely. Lenders account for the high risk of lending by raising interest rates on loans charged or by rationing credit. Borrowers are more likely to get their loan requests rejected. Medical service providers pass on the costs of bad debt to consumers in the form of higher prices——

Mr. COHEN. Dr. Mathur, we are getting into the red world.

Ms. MATHUR. Yes. I am almost done. I will—imagine——

Mr. COHEN. You are beyond almost done.

Ms. MATHUR. Imagine not getting a loan to pay for your prescriptions and other medical bills. In short, the lives of borrowers—particularly honest borrowers—are made worse off. In my opinion the 2005 law introduced the means testing requirement to restrict this kind of strategic behavior, and there is no real justification to amend that law.

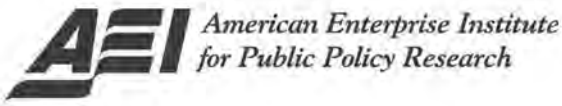
To conclude, we obviously cannot wish illness away. However, some solutions may help families deal with the situation better. For example, employers and employees could try to come up with flexible work arrangements that would enable the employee to function even in the middle of a medical crisis. Job loss should not be the inevitable result of a prolonged medical condition.

Finally, the act could be modified to allow debtors to obtain relief under Chapter 7 only on the medical debts rather than all of their other debts as well. This may reduce the misuse of the system by opportunistic debtors.

Thank you.

[The prepared statement of Ms. Mathur follows:]

PREPARED STATEMENT OF APARNA MATHUR



Statement before the United States House of Representatives
Committee on the Judiciary
Subcommittee on Commercial and Administrative Law
Hearing on "The Medical Bankruptcy Fairness Act"

Aparna Mathur

Resident Scholar and Jacobs Associate

American Enterprise Institute

Thursday, July 15, 2010

The views expressed in this testimony are those of the author alone and do not necessarily represent those of the American Enterprise Institute.

Mr. Chairman and Distinguished Members;

Thank you for inviting me to testify before the Committee on the Medical Bankruptcy Fairness Act (2009). The Act is intended to introduce certain amendments to the Bankruptcy Abuse Prevention and Consumer Protection Act (BAPCPA) of 2005 to make the bankruptcy process easier for medical debtors. While most would agree that there are obvious benefits to this proposal, my testimony will caution against the not-so-obvious but nonetheless tremendous costs that such a proposal could impose on the bankruptcy system. Before we move forward with this proposal, we need to clearly weigh both the benefits and the costs of doing so.

The role of the bankruptcy system is critical in today's economic environment. The U.S. economy is in the midst of a fragile recovery from the Great Recession. Millions of families are struggling to make ends meet. In a recent speech, Janet Yellen of the Federal Reserve Bank of San Francisco remarked that of those officially counted as unemployed, nearly 44 percent have been jobless for at least six months, a far bigger share than in any previous postwar recession. If instead we look at a broader measure of underemployment-those who are discouraged from seeking work and who are working part-time-the unemployment rate jumps to 16.9 percent.[1] This represents a real tragedy for our society. The loss of a job is a catalyst for economic hardships for families, since low incomes erode their ability to meet basic expenses, leading to unsustainable debts and often a bankruptcy filing.

The Medical Bankruptcy Fairness Act focuses on medical debtors. Given the current economic climate, the focus on medical debtors to the exclusion of other debtors is somewhat surprising. I believe that the urgency to tackle the issue of medical bankruptcies is being largely justified through the use of studies claiming that more than 60 percent of all personal bankruptcy

[1] http://www.frbsf.org/news/speeches/2010/janet_yellen0415.html

filings are caused by medical debt. I hope that through my testimony I will be able to dispel the belief that medical bankruptcies are such a large fraction of all bankruptcies today. Having said that, the attempt here is not to belittle the hardship suffered by families struggling with medical bills. The question we are concerned with today is whether a reform of the bankruptcy code, as put forward in the Medical Bankruptcy Fairness Act, would provide a solution to the problem of medical bankruptcies.

My testimony will first focus on whether evidence supports the essential premise underlying the introduction of the Medical Bills Fairness Act which appears to be the much debated surge in medical bankruptcies in recent times. Second, it will explain how the bankruptcy code currently affects medical debtors. Third, it will provide details on the proposed reform and its practical applicability. Finally, it will explore the possible abuse of the Act based on a literature review of the effect of bankruptcy laws on debtor behavior.

I. Medical Debts and Bankruptcies

The Medical Bankruptcy Fairness Act is intended as a solution to the problem of rising medical bankruptcies. While I applaud the goals underlying the Act, I also believe that it results from a mis-diagnosis of the problem. The essential premise of the Medical Bankruptcy Fairness Act of 2009 is that today medical debts are the leading cause of consumer bankruptcy filings in the U.S. and therefore medical debts need to be addressed differently from other debts. How valid is this supposition?

The American Bankruptcy Institute provides statistics on consumer bankruptcy filings for the U.S. since 1980.[2] The data show a rise in filings from about 1.2 million in 2000 to 2.0 million in 2005. In 2006, filings dipped to 617,600 presumably due to the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 which instituted a means-test provision by which only low income filers could file for bankruptcy and discharge their (unsecured) debts. More importantly, since the start of the recession, filings have risen from about 850,000 in 2007 to nearly 1.5 million in 2009. What fraction of this is due to medical debts?

Household level data on medical debts is available from the Survey of Consumer Finances (SCF).[3] The SCF survey samples approximately 4500 households every three years to assess families' financial situations and provides a picture of their debt and asset levels. The households are randomly selected to avoid biased results. A look at the latest SCF data (2007) shows that medical indebtedness has not changed significantly over the past decade or so. The SCF includes medical debts with other debts incurred for "goods and services", including credit card debt. These debts have risen marginally from 5.5 percent of all debt in 2001 to 5.8 percent in 2007, and have in fact, declined over a 10 year period by 0.2 percentage points.[4] The SCF shows that this change is mainly being driven by rising credit card debts where the average value has increased from $4800 to $7300 (Medical debts are excluded from the credit card debt category). Even if all credit card debt were medical debt, it is still hard to conclude that medical debts are responsible for an increasingly large fraction of bankruptcy filings. A paper by Bucks (2008) analyzing the SCF data for 1989-2004 shows, in fact, that the number of families

---

[2] http://www.abiworld.org/AM/AMTemplate.cfm?Section=Home&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=57826

[3] http://www.federalreserve.gov/pubs/oss/oss2/scfindex.html

[4] The largest categories of debt are mortgages and vehicle loans.

reporting any medical debt has declined from 3.6 percent in 2001 to 2.8 percent in 2004. [5] The same paper also shows that medical debts as a fraction of all debts have remained steady at 0.3 percent between 2001 and 2004.[6] My own analysis of the 2007 data shows that only 2.4 percent of families reported any medical debt, and only 2.8 percent of families reported that they would save for future medical expenses.

At an aggregate level, national health expenditures data show that out-of-pocket medical payments as a fraction of total health expenditures have, in fact, been declining since 2000 from 14.4 percent of all expenditures to 11.8 percent in 2008 (Figure 1).[7] (Figure 2 shows how this compares to out-of-pocket spending in other countries)

To summarize, while bankruptcy filings have increased by 25 percent since the start of this decade, medical debts (or even credit card debts in total) have not changed significantly as a share of total debt over this period. It seems obvious to me that medical debts could not be a significant factor in raising consumer bankruptcies.

The literature on bankruptcies and medical debts can methodologically be divided into two streams, one that has focused on survey data and the other on empirical regression analysis. For instance, relying on surveys of 1032 bankruptcy filers, Himmelstein et al. (2009) conclude that approximately 62 percent of all bankruptcies in 2007 were "medical."[8] Their earlier study (Himmelstein et al. (2005)), based on a 2001 survey of 1000 filers, concluded that approximately

[5] http://www.iariw.org/papers/2008/bucks.pdf
[6] Data for 2007 are not available from the paper.
[7] https://www.cms.gov/NationalHealthExpendData/01_Overview.asp
[8] Himmelstein, David, Warren, Elizabeth, Thorne, Deborah and Woolhandler, Steffie (2009), "Medical Bankruptcy in the United States, 2007: Results of a National Study", The American Journal of Medicine, available at: http://pnhp.org/new_bankruptcy_study/Bankruptcy-2009.pdf

46 percent of all bankruptcies had medical causes.[9] Note that in both studies, "medical" refers to all sorts of medical reasons for a bankruptcy filing, not just medical debts. These include lost weeks of work due to own illness or spouse's illness, as well as when the debtor said that a medical problem of a family member caused the bankruptcy filing. The idea that medical bankruptcies are on the rise comes essentially from these two studies. In the Appendix to this testimony I discuss methodological problems with these studies that may lead to biased results. However, even if we take their estimates at face value to calculate the fraction of medical bankruptcies in total bankruptcies, the number of medical bankruptcies has in fact declined from 667,933 (46 percent of 1,452,030) in 2001 to 510,005 (62 percent of 822,590) in 2007. Hence there is little to suggest that there has been a surge in medical bankruptcies that warrants a big change in the bankruptcy code.

Further, the survey results shown in Table 2 (Page 3) of the study clearly state that only *29* percent of the respondents believed that their bankruptcy was actually *caused* by medical bills. However, the authors chose to add to this number the percent of people who lost weeks of work due to illness, the percent of people with more than $5000 in medical bills, and the percent of people reporting any medical problems. This is clearly an overstatement of the problem. Since the respondents themselves do not believe that these other factors caused the bankruptcy filing, it is wrong to ascribe the additional bankruptcy filings to their medical costs. A related point is that the survey fails to provide information on other causes of the bankruptcy filing or how the respondents would rank different factors, as in the PSID. Therefore, it is unclear whether medical bills were the most important cause or just another cause.

[9] Himmelstein, David, Warren, Elizabeth, Thorne, Deborah and Woolhandler, Steffie (2005), "Illness and Injury as Contributors to Bankruptcy", *Health Affairs* (Web Exclusive), 2 February

This criticism was also raised by Dranove and Millenson in reference to the 2005 paper.[10] Exhibit 2 of that paper identified people who stated that illness or injury was a cause of bankruptcy (although not necessarily the most important cause). According to Himmelstein and colleagues, 28.3 percent of respondents stated that illness or injury was a cause of bankruptcy. They also reported that medical bills contributed to the bankruptcy of 60 percent of this group. Multiplying the two figures together, Dranove and Millenson conclude that 17 percent of their sample had medical expenditure bankruptcies. Even for that 17 percent, it cannot be stated with any degree of certainty whether medical spending was the most important cause of bankruptcy.

Most other studies in fact suggest a minimal role for medical debts in bankruptcy. The closest comparable survey to the Himmelstein et al. studies is a study of bankruptcy filers by the Department of Justice's Executive Office of the United States Trustee (USTP). The USTP examined the records of 5,203 bankruptcy cases filed between 2000 and 2002, the most thorough study of the problem to date of those who actually filed bankruptcy. It reported that 54 percent of the cases in the sample listed no medical debt, meaning that the median amount of medical debt in the study was zero. Medical debt accounted for 5.5 percent of total general unsecured debt and 90.1 percent of filers reported medical debts less than $5,000.

A more nationally representative survey is the Panel Study of Income Dynamics (PSID), which is a longitudinal survey tracking households since 1968.[11] In 1996, the PSID asked respondents whether they had ever filed for bankruptcy between 1996 and 1984, and if so, what were the primary, secondary and tertiary reasons for filing from a given a list of possible reasons, which included medical bills, job loss, injury or illness, etc. This is the most definitive survey so

[10] Dranove, David and Millenson, Michael, L. (2006), "Medical Bankruptcy: Myth vs Fact" HEALTH AFFAIRS 74 (2006)
[11] http://psidonline.isr.umich.edu/

far in terms of determining the proximate cause of a bankruptcy filing. The largest contributor to bankruptcy filings was high credit card debt. Nearly 42 percent of respondents reported high credit card bills as the primary reason for filing, while an additional 9 percent claimed it as the secondary reason for filing. Other big reasons were job loss (13 percent) and divorce or separation from spouse (12 percent). Only 9 percent of the sample claimed medical bills as the primary reason for filing, and 7 percent claimed it as a secondary reason.

By their very nature, survey data are unable to account for a host of other factors that might help explain why households file for bankruptcy. For instance, factors like average household wealth and income, state-level factors such as bankruptcy exemptions and unemployment rates, and household expenditures such as rent and taxes could each play a significant role in a household's decision to file for bankruptcy. The standard methodology in the economics literature for accounting for all of these factors is multivariate regression analysis. With regression analysis, it is possible to study the effect that each factor has on the probability of filing for bankruptcy while holding the effect of all other variables constant. This is the only way that one can establish causation, rather than correlation. In other words, only when we use regression analysis to control for the effect that each of the other factors has on a bankruptcy filing can we be sure that medical debts are significant determinants of bankruptcy filings.

Fay, Hurst, and White (2002) study PSID (Panel Study of Income Dynamics) data from 1996. Their data included 254 filers. They compared that sample of filers to a much larger sample of non-filers to identify determinants of bankruptcy demand. Consistent with the strategic model, they find that differences in the *net benefit* of filing, computed based on individual debt, income, assets, and exemptions (as determined by residence), played a major role in the decision to file. By contrast, medical problems were not significant determinants of a bankruptcy filing.

A 1999 study by Ian Domowitz and Robert Sartain in the *Journal of Finance* uses exactly this approach. The authors examined 827 households who filed for bankruptcy in 1980 matched against 1,862 households not in bankruptcy. Accounting for prevalence of various sources of debt, Domowitz and Sartain found that "the largest single contribution to bankruptcy at the margin is credit card debt." Medical debt does matter, but only when combined with other forms of unsecured debt.

In an AEI Working paper that I wrote, I estimated a model of the household bankruptcy filing decision, using PSID data for the period 1994-1996 and a three year panel covering the years 1984, 1989 and 1994 respectively.[12] The main aim in the paper was to test whether medical debts can be ascribed as the leading cause of bankruptcy filings. The results from my paper do not support the view that medical debts are the *leading* cause of bankruptcy filings. In fact, households who are most likely to file are those with *primarily* other forms of debt, such as credit card or car debts, who *also* incur medical debts.

To summarize this section, most data using simple sample averages, including the Himmelstein et al. studies, suggests that medical debts could be the immediate cause for between 9 to 17 percent of all bankruptcies. Further, most empirical studies find either no role or a marginal role for medical debts in explaining consumer bankruptcies. Therefore, if that is the essential premise of the Medical Bankruptcy Fairness Act, then the foundations of the Act are built on shaky grounds.

II. Current Bankruptcy Code and Proposed Reforms

[12] "Mathur, Aparna (2006), "Medical Bills and Bankruptcy Filings," AEI Working Paper http://www.aei.org/paper/24680

How does current bankruptcy law affect medical debtors? Under current law, debts incurred for medical treatments are completely dischargeable under Chapter 7 of the bankruptcy code. This includes services provided by doctors, hospitals, dentists, chiropractors, physical therapists and other medical providers. In addition to medical debts, Chapter 7 also eliminates other unsecured debts such as credit card debts and personal loans. Therefore individuals who have piled up high medical debts on their credit cards can get that debt discharged as well. The advantage of a Chapter 7 bankruptcy is that debtors can retain some or all of their property and shield it from being used to repay creditors at the time of a bankruptcy filing. The value of assets that they can protect depends upon the exemption level in the state of filing. Exemption levels can range from a few thousand dollars to more than $100,000.

The Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 instituted a means-test provision by which only filers with incomes below the median income in their state could file for bankruptcy and discharge their (unsecured) debts under Chapter 7. In most cases, the payments will be based upon what the individuals can afford, rather than what they owe. High-income debtors who can repay a substantial portion of their debts without significant hardship are required to enter a Chapter 13 plan and repay as much as they can of their unsecured debts as a condition for filing bankruptcy, whether 40%, 60%, or 80% of their outstanding unsecured debt. Moreover, in calculating the debtor's income available to repay debts in Chapter 13, the law permits a deduction for health insurance and other health expenses. Finally, a judge retains discretion to permit an otherwise-ineligible debtor to file in Chapter 7 if she can show special circumstances, such as "a serious medical condition."

In short, current law adequately accommodates the claims of those debtor laid low by medical problems and expenses and other innocent parties who are affected by bankruptcy including health care professionals and other consumers.

The Medical Bankruptcy Fairness Act of 2009 will reform the current system in the following ways. First, the Act would amend Section 101 of the Bankruptcy Code, which is more commonly known as the definitions section. Section 101 would be amended to add the definition of a "medically distressed debtor" as a debtor, or a dependent of the debtor, who has in excess of the lesser of 25 percent of the household income or $10,000.00 of medical debt (which was not covered by insurance) in a twelve month period in the last three years or lives in a household with a person who was out of work for four weeks in the last twelve months due to medical reasons.

Second, it would allow these medically distressed individuals to claim an exemption against their home of $250,000. This would override any state homestead exemptions that would typically vary from a low value of $5000 to more than $100,000.

Finally, it would also remove the means-testing requirement for medically distressed debtors. In other words, all individuals defined as being medically distressed debtors could file under Chapter 7, even if their mean income was above the median income in their state.

While the purpose of the Act is to make the bankruptcy process easier and more efficient for medical debtors, there are several unintended consequences and problems with the proposed reforms to the bankruptcy code that I outline below.

(1) Definition of medically distressed debtor

The definition of a medically distressed debtor is open to abuse and fraud. By definition, a medically distressed debtor is anyone who incurred debts of the lesser of $10,000 or 25 percent of income at any time within a twelve month period in the three years prior to the filing. To see what this implies for the actual level of medical debts, it is helpful to look at a typical distribution of bankruptcy filers by income level. A study of the distribution of bankruptcy filers by income in 2000-2002 showed that more than 85 percent of filers had annual incomes less than or equal to $48,000, with almost 60 percent earning between $12,000-$36,000.[13] This means that if the average filer spent about $3000-$9000 on medicines or medical care in any year, then they would qualify for a medical bankruptcy. The same study shows that credit card debts average approximately $15,000 for this group of low-income borrowers. In the worst case scenario, this could create perverse incentives for households since by accumulating medical debts, they could take advantage of the high exemptions and the debt discharge provisions of Chapter 7 to get rid of their high credit card debts. In fact, it might even tempt households to accumulate other types of debt prior to the filing, since they are eligible for debt discharge under Chapter 7. Therefore, by allowing debtors to file as medical debtors irrespective of whether medical debts are actually driving the household to bankruptcy, the Medical Bankruptcy Fairness Act would essentially be providing relief from credit card debt rather than medical debts.[14]

A second problem with this definition is that it imposes huge informational requirements for a bankruptcy filing. For an attorney to establish a debtor as a medically distressed debtor, they would have to go back three years in either their, or one of their dependent's, medical history and determine that at any one time during that three year period, was there a specific time

[13] Marianne B. Culhane & Michaela M. White, *Taking the New Consumer Bankruptcy Model for a Test Drive: Means-Testing Real Chapter 7 Debtors*, 7 AM. BANKR. INST. L. REV. 27, 37–38 (1999); Ed Flynn & Gordon Bermant, *Bankruptcy by the Numbers: Chapter 7 Asset Cases*, AM. BANKR. INST. J., Dec. 2002–Jan. 2003

[14] http://weber.ucsd.edu/~miwhite/UIll-law-review--final.pdf

when the debtor or one of their dependents had more than $10,000.00 outstanding in medical debt which was confined to a twelve month period. Then, they would have to determine whether the debtor had insurance, and what bills, if any, were either paid by insurance or not. It is extremely hard to imagine that debtors would be able to provide such detailed medical bills for themselves as well as their family, along with all the insurance documentation.

(2) No Means Testing

The means test incorporated into the bankruptcy code in 2005 was designed to limit the use of Chapter 7 bankruptcy to those who truly cannot pay their debts. In effect, it limits the ability of high income filers to walk away from their debts when they have the ability to pay for them by forcing them into Chapter 13 bankruptcy. This increases efficiency and ensures that creditors get at least a minimum return on their debt. Doing away with the means test under the Medical Bankruptcy Fairness Act would allow high income individuals to walk away from not only their medical debts, but also other debts such as credit card debts. For instance, it is typically the case that families incurring high medical debts, especially due to job loss or other adverse events, also incur other debts, such as car loans, unpaid utility bills, credit card debts etc. If medical filers are no longer subject to means testing, then high income debtors would have an easier time walking away from their other dischargeable debts. In the study of bankruptcy filers cited earlier, those with incomes higher than $70,000 had average credit card debts of $42,000. Allowing this group to take advantage of the debt discharge provisions under Chapter 7 would hit creditors particularly hard. This is the exact situation that the 2005 bankruptcy reform tried to address. One possibility to avoid such a situation could be to set higher percentage of income thresholds for medical debt for higher income households, to allow eligibility for a Chapter 7 bankruptcy.

(3) Effect on Creditors

The Act does little, if anything at all, for the creditors in these medical transactions. As discussed in the previous two paragraphs, there could be potentially serious consequences for medical service providers if we make it easier for debtors to file for medical bankruptcy involving the discharge of all medical debts. In fact, research has shown that between 1994 and 2000, unsecured creditors received nothing in about 96 percent of Chapter 7 bankruptcy filings, and in most Chapter 13 cases, only mortgage creditors received anything at all.[15] These higher costs of bad debts will ultimately be passed on to consumers in the form of higher prices for care or poor delivery of care.

(4) Exemption Limits Raised

There is now a fairly large volume of economics papers that discusses how high bankruptcy exemptions affect debtor behavior. Debtors value high exemptions because it provides them with consumption insurance by discharging some or all of their debts when a drop in income would otherwise have caused a drop in consumption. However, because higher exemptions for wealth and income make filing for bankruptcy more attractive, studies show that the number of filings increases when exemptions increase.[16] This adversely affects the market for credit. To insure against the probability of a bankruptcy filing, lenders raise interest rates or ration credit,[17] which

[15] Stewart E. Sterk, *Asset Protection Trusts: Trust Law's Race to the Bottom?*, 85 CORNELL L. REV. 1035, 1036 (2000).
[16] Michelle J. White, *Personal Bankruptcy Under the 1978 Bankruptcy Code: An Economic Analysis*, 63 IND. L.J. 1, 45–46 (1987) (discussing data indicating that an increase in the bankruptcy exemption level corresponds with an increased bankruptcy filing rate).
[17] Reint Gropp, John Karl Scholz, & Michelle J. White, *Personal Bankruptcy and Credit Supply and Demand*, 112 Q.J. ECON. 217 (1997) (showing that higher exemption levels result in higher interest rates).

harms debtors who repay as well as those who would like to borrow but are rejected.[18] Hence creditors alter behavior when faced with higher exemptions.

At the same time, the incentive for debtors under these high exemption limits is to reallocate all wealth from non-exempt assets to exempt assets. For instance, if the homestead exemption were raised to $250,000 the individual would have an incentive to convert all non-housing assets to housing (say by using all available bank accounts to pay off the mortgage), so as to protect more of their income and wealth from the creditors. Therefore, there are both costs and benefits to having higher exemption limits that need to be recognized.

To summarize this section, what the Medical Bankruptcy Fairness Act would do is make the financial benefit from filing for a *medical* bankruptcy higher than the financial benefit of filing for any other type of bankruptcy. The higher exemption levels, the lack of means testing and the potential to identify oneself as a medical debtor would clearly lead to strategic behavior on the part of some opportunistic debtors. Medically distressed debtors who are able to file under Chapter 7 would use this to get rid of their credit card debts. This would be especially advantageous for high income debtors who are unable to file for Chapter 7 bankruptcy under the current code. This large scale discharge of credit card debts, available even to debtors with the ability to repay some of their debts, is one aspect of the previous bankruptcy code that the 2005 reform sought to undo. We need to understand therefore, that the changes being considered under the Medical Bankruptcy Fairness Act could impose tremendous costs on the system while conferring benefits to a few.

---

[18] The optimal exemption levels in bankruptcy are determined by trading off debtors' gain from having additional consumption insurance and better work incentives when exemption levels are higher against their losses from higher interest rates and reduced access to credit. For a formal model and simulations, see Michelle J. White, Personal Bankruptcy: Insurance, Work Effort, Opportunism and the Efficiency of the "Fresh Start," (May 2005) (unpublished manuscript, on file with author), *available at* http://www.econ.ucsd.edu/~miwhite/bankruptcy-theory-white.pdf, and Hung-Jen Wang & Michelle J. White, *An Optimal Personal Bankruptcy Procedure and Proposed Reforms*, 29 J. LEGAL STUD. 255, 265 (2000).

We obviously cannot wish illness away. However, some solutions may help families deal with the situation better. For example, employers and employees could try to come up with work arrangements that would enable the employee to function effectively even in the midst of a medical crisis. Job loss should not be the inevitable result of a prolonged medical condition since this increases the financial pressure on families. Government initiatives such as the formation of high risk pools may also alleviate the burden to a certain extent, though they need to be designed such that they do not impose tremendous fiscal pressure on an already tight federal budget. Finally, the Act could be modified to allow debtors to obtain relief under Chapter 7 only on their medical debts, rather than all of their other debt as well. This may reduce misuse of the system by opportunistic debtors.

III. Conclusion

To summarize, the case for bankruptcy reform to help medically distressed debtors is built on somewhat shaky foundations. While the intentions are laudable, there is little to support such an intervention based purely on the incidence of medical debts in bankruptcy filings. Despite some recent survey evidence suggesting that medical debts account for more than 60 percent of all filings, more rigorous analysis finds a relatively smaller proportion of bankruptcies that can be attributed to medical debts.

Further, the Medical Bankruptcy Fairness Act could create perverse incentives for debtors to accumulate non-medical debts prior to a filing, as long as they can file as medically distressed debtors. The Act attempts to overturn several features of the bankruptcy reform enacted in 2005 by doing away with a means test for medical debtors and allowing medical debtors to claim a homestead exemption higher than that allowed under the current code in

several states. This could have adverse consequences on at least two fronts. One, high income filers with the ability to repay their debts can get complete debt relief under Chapter 7, while imposing losses on their creditors. Two, the high homestead exemptions could affect credit markets by causing creditors to raise the interest rate on loans provided and/or ration credit. In other words, the proposed reform could have unintended adverse consequences for debtors as well.

I believe that any situation that causes a household to file for bankruptcy is unfortunate. In these tough economic times, individuals who lose their job for no fault of theirs are as badly affected as families hit by illnesses or injuries. Individuals who lose their homes because of a painful divorce are no worse off than people who are unable to pay their mortgages due to an unexpected change in credit conditions. Therefore, there is little to justify amendments to BAPCPA based on this criterion. Looking for solutions outside the bankruptcy code may work better.

Figure 1: Out-of-Pocket Expenditures as a Percent of National Health Expenditures, US

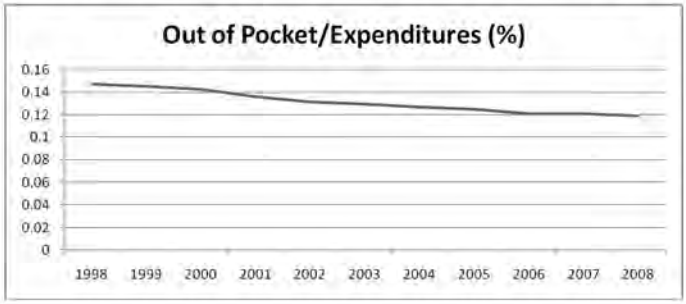
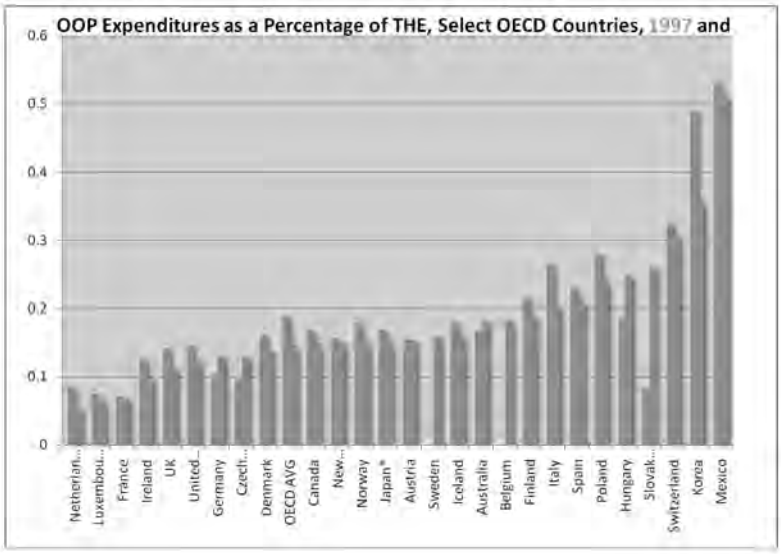


Figure 2: A Comparison of Out-of-Pocket Expenditures in the OECD countries



Appendix

Problems with the Himmelstein et al. (2005 and 2009) Studies

(1) Sample Selection Issues

A major shortcoming with both the Himmelstein et al. (2005 and 2009) studies is what economists dub the "sample selection issue". Himmelstein et al. (2005, 2009) conducted a survey of bankruptcy filers from public court records for the year 2001 and 2007. Based on a sample of 1000 debtors, they concluded that more than 50 percent of these had filed for bankruptcy due to a medical reason. By limiting the sample to those who had already filed for bankruptcy, the study overstated the incidence of medical debt. To account for causation, the study sample should have, at the very least, included a "control" group of medical debtors who did not file for bankruptcy. In other words, if the authors were trying to establish whether medical debts *cause* bankruptcy filings, the appropriate sample should have included households with and without medical debt, and households who filed or did not file for bankruptcy. In short, what the authors have established is some correlation, but not causation.

The sample also seems skewed towards debtors with high medical debt. The USTP report of bankruptcy filers, which included a much larger sample of 5203 filers, found that 90 percent of filers had medical debts less than $5000. The Himmelstein et al.(2009) study reports nearly 35 percent of filers with more than $5000 in medical debt. The authors make no attempt to reconcile or explain their findings or reveal the distribution of medical debts across filers in their sample.

(2) Regression Analysis

The study also should have allowed for the possibility that other household characteristics, such as the filer's work status, marital status, income, and other kinds of debts

could have influenced the filing. As explained earlier, this could be done through the use of appropriate regression techniques applied on a suitably large, random sample of filers and non-filers. Mainstream economics literature discussing the relationship between debts and bankruptcy amply outlines these standard considerations. The study does claim to have done multivariate analysis, but the analysis is done on an even more restricted sample than the original 1032 in 2007. The sample only includes people who reported having any medical bills. Therefore, it simply assumes that medical debts are important for bankruptcy filing, rather than testing for that hypothesis in the entire sample of bankruptcy filers.

(3) *Definition of Medical Bankruptcy*

The 2005 study used an overly broad definition of "medical filers," which included people with any sort of addiction or uncontrolled gambling problems. The 2009 study removed these clauses but still came up with a 62 percent number i.e nearly 62 percent of bankruptcy filings are due to medical reasons. The reason for the high number is puzzling, though as mentioned earlier, it is partly driven by the fact that the authors ascribe any remotely medical factor as causing the bankruptcy filing, not just medical debts. The survey results shown in Table 2 (Page 3) of the study clearly state that only *29* percent of the respondents believed that their bankruptcy was actually *caused* by medical bills. However, the authors chose to add to this number the percent of people who lost weeks of work due to illness, the percent of people with more than $5000 in medical bills, and the percent of people reporting any medical problems. This is clearly an overstatement of the problem. Since the respondents themselves do not believe that these other factors caused the bankruptcy filing, it is wrong to ascribe the additional bankruptcy filings to their medical costs. A related point is that the survey fails to provide information on other causes of the bankruptcy filing or how the respondents would rank different

factors, as in the PSID. Therefore, it is unclear whether medical bills were the most important cause or just another cause.

This criticism was also raised by Dranove and Millenson in reference to the 2005 paper.[19] Exhibit 2 of that paper identified people who stated that illness or injury was a cause of bankruptcy (although not necessarily the most important cause). According to Himmelstein and colleagues, 28.3 percent of respondents stated that illness or injury was a cause of bankruptcy. They also reported that medical bills contributed to the bankruptcy of 60 percent of this group. Multiplying the two figures together, Dranove and Millenson conclude that 17 percent of their sample had medical expenditure bankruptcies. Even for that 17 percent, it cannot be stated with any degree of certainty whether medical spending was the most important cause of bankruptcy.

[19] Dranove, David and Millenson, Michael, L. (2006), "Medical Bankruptcy: Myth vs Fact" HEALTH AFFAIRS 74 (2006)

Mr. COHEN. Our next witness is Professor Wright. Professor Wright is the director of clinical programs, Consumer and Commercial Law Clinic at the Franklin Pierce Law Center. During 18 years of practice in the public and private sectors, Professor Wright handled civil trials and appeals in state, Federal and bankruptcy courts on behalf of individuals and corporate clients.

His public service included 4 years as a member of the New Hampshire Workers Compensation Appeals Board, 2 years as mediator at the New Hampshire Department of Labor, and 12 years as a hearing officer in the Federal Medicare program. Actively involved in efforts to improve the Administration of justice, in 1993 and 1995 he was chair and co-chair of state conferences devoted to this subject. Professor Wright has been here before. He is aware of our 5-minute system.

And I would ask you to accept that. You are now recognized.

TESTIMONY OF PETER S. WRIGHT, JR., DIRECTOR OF CLINICAL PROGRAMS, CONSUMER AND COMMERCIAL LAW CLINIC, FRANKLIN PIERCE LAW CENTER

Mr. WRIGHT. Thank you. Chairman Cohen, distinguished Members, good morning.

I have got the button on. Is it? Oh, all right. I am sorry. How is that? Better? All right.

I appreciate the opportunity to be here to share with you the perspective that I might offer as a clinical professor, who is essentially running a legal aid program in which the students serve as lawyers. Because our focus is on consumer credit, these days the kind of cases we are handling involve foreclosure defense, credit card defense and consumer bankruptcy.

I appreciate the opportunity to speak to the merits of H.R. 901, because in our clinic we have witnessed many examples of the types of debtors which are described in H.R. 901 as a medically distressed debtor. I would like to give you a couple of examples of the profile of these clients. And I think this will be instructive, because within H.R. 901 there is actually a very thoughtful definition of the medically distressed debtor.

The issue that we spend so much time talking about of the percentage of people who are driven to bankruptcy by massive debt is only one of the definitions. The other two definitions actually capture the type of debtor that we most frequently see as medically distressed. And that is the type of debtor who is unable to work or experiences a severe and prolonged loss of income, because they are caring for a family member or they themselves are stricken with a serious medical condition.

Examples of such clients—we saw one family where the wage earner was a over-the-road or door-to-door salesman for Comcast, selling cable subscriptions. And he would drive around in his own vehicle making his rounds. He was involved in a head-on accident, head-on automobile collision, which put him in the hospital for 6 weeks.

When he was released and undergoing physical therapy, he really couldn't pursue his work of driving and walking and knocking on doors, so he got behind on everything. He had insurance, because he worked for Comcast, but what he didn't have was any means of paying his mortgage, so that fell into default along with this car payment and everything else.

Another example is a young couple. They owned a condominium. The husband, who worked as a roofer, developed cancer. He could not work, as he devoted his full time and attention to handling that medical problem. He was successful in overcoming the cancer, but

during the time he was out of work, his mortgage fell into arrears, his car was repossessed, and he was not able to pay the credit card bills and other bills for the family.

Net result was he had to file bankruptcy to clear up the deficiency after his condominium was foreclosed. Again, this is an example of someone who, because of the medical condition, was unable to pay the ongoing bills to hold on to the necessities—house, car, et cetera.

And finally, we just took a case in this last week where the individual who is the wage earner, who happened to be a mortgage broker, made a lot of money during the bubble, had a heart attack while he was driving, and the impact of the accident and the heart attack had him laid up enough that he ran up $200,000 in medical bills. Then he died, leaving his widow with a house in foreclosure, plus all these medical bills.

This last situation illustrates what I think is the significance of high medical bills. They are often a symptom or an incidental impact caused by a severe medical problem, which is really the hallmark of the distressed medical debtor.

Now, H.R. 901 is very skillfully crafted and carefully crafted and narrowly drawn to provide relief to people who are truly medically distressed debtors as defined in the last two parts of the definition—that is, who have experienced either loss of child support, alimony or who have lost their income because of a medical catastrophe. The first definition, of course, is the one where there is massive—or actually medical debt which reaches the levels that we discussed earlier.

Now, what is the relief that 901 provides? It is an enhanced version—an enhanced amount of the homestead exemption. As you know, it would increase the homestead exemption to $250,000 regardless of whether the debtor is filing using the Federal exemption, which would otherwise only be $20,200 for homestead, or the state exemptions.

It raises both of those exemption levels to $250,000. And this is laudable, because it enables a debtor to hold onto the homestead, even if they lose everything else through a Chapter 7, but it also enables them to have a workable and feasible Chapter 13, if they are able to remove the value of their homestead from the liquidation test, which we could talk about.

It is a little technical, but it really is a major plus, because many elderly people, who have a lot of equity in their homes, are not able to qualify for Chapter 13, because they can't pass the liquidation test.

And as I am out of time, I will not speak to the means test right now, but thank you for the opportunity.

[The prepared statement of Mr. Wright follows:]

PREPARED STATEMENT OF PETER S. WRIGHT, JR.

Statement before the United States House of Representatives

Committee on the Judiciary

Subcommittee on Commercial and Administrative Law

Hearing on H.R. 901 the "Medical Bankruptcy Fairness Act"

Peter S. Wright, Jr., Esq.

Professor of Law

Franklin Pierce Law Center

Concord, New Hampshire

Thursday, July 15, 2010

The views expressed in this testimony are those of the author alone and do not necessarily represent those of Franklin Pierce Law Center or its affiliate, University of New Hampshire

Mr. Chairman and Distinguished Members:

My name is Peter Wright and I am a clinical law professor at Franklin Pierce Law Center in Concord New Hampshire. My job involves supervising and mentoring law students in the development of professional skills as we represent real-life clients in a variety of cases. My clinic, the Consumer and Commercial Law Clinic, operates year round and accepts cases on behalf of low income clients whose problems involve consumer credit, mortgage foreclosure defense, and consumer bankruptcy. I have held this position since 1998 when I left private practice to pursue a teaching career.

The perspective I bring to bear on H.R. 901 is necessarily shaped by my allegiance to the low income debtors whom I represent in bankruptcy court. I have also had first had experience observing the impact of debilitating medical conditions upon elderly citizens through the fourteen years I served part time as a Medicare hearing officer. In this position, I directly observed the struggles of elderly citizens challenging the denial of claims for benefits in what is admittedly a complex and confusing system of federally funded health care. I also heard from them about the financial setbacks they endured because of inadequate reimbursement of claims or the denial of coverage for claims which were appealed. In many cases the onset of debilitating medical conditions prevented them from continuing to earn money to supplement their meager retirement funds. In a number of cases I would hear how unanticipated medical conditions saddled them with debt not covered by the Medicare program or through non participating providers.

I come before the committee today to share my perspective from the trenches of the plight of individuals who are forced to seek bankruptcy protection because of prolonged illness, the effects of accident or other medical catastrophe. Because the legal services we provide are offered without charge, the demand for our services is overwhelming. Our intake process is largely a matter of triage. Most of the cases we see these days involve mortgage foreclosure defense, counseling and intervention into the HAMP and private loan modification programs, and representing individuals seeking relief through bankruptcy. In the face of the pressure of so many calls for assistance, we give first priority in our bankruptcy acceptance process to homeowners seeking to retain their homestead, rather than simple debt relief. A very important factor is whether the individual has lost control of budget and finances because of a medical calamity. Those cases receive heightened priority in our case acceptance process.

Because of our acceptance criteria, I am not able to offer any objective statistics to the debate which this committee has heard in the past about whether or not medical bills are a driving force in the bankruptcy. I can provide anecdotal evidence based upon the triage we perform that the principal drivers of consumer bankruptcy are prolonged unemployment, catastrophic and chronic medical conditions with related bills, and divorce. It is true that some individuals are poor money managers and amass staggering amounts of consumer debt, often owed to credit card companies. We tend not to accept such cases so that we may be available to those cases driven by long term unemployment, prolonged and serious medical conditions or divorce.

It is certainly true that medical debt related to serious and long-term illness can push a family to bankruptcy. Such debt can arise even when the family has health insurance coverage

because of co-pays, deductibles, and limitations in coverage. In my experience the incidence of medical debt and interruption of income caused by the illness or injury have a cumulative effect which often propel the debtor and family to seek bankruptcy protection. Because so many families are living paycheck to paycheck on the edge of financial calamity, any significant interruption in income pushes them over the edge. Late payments on credit cards trigger default penalties and outrageous interest rates. Late mortgage payments set in motion an impossible game of catch-up with partial payments held in suspense and even complete payments treated as partial when late-penalties are deducted. We have seen unemployment figures exceed 10% during the recent economic crisis. While many of these cases are caused by layoffs during the slowdown, the disruption of work because of prolonged illness can be every bit as devastating to the family income.

H.R. 901 recognizes this critical fact by devoting two of the three definitions of "medically distressed debtor" to the situations where the individual's income is interrupted. The first, 39B (B) defines "medically distressed debtor" as a debtor who, in any consecutive 12 month period during the three years before the date of the filing of the petition –

> Was a member of the household in which one or more members (including the debtor) lost all or substantially all of the members' employment or business income for four or more weeks during such 12 months due to a medical problem of a member of the household or dependent of the debtor;

The second definition which recognizes that a medical condition can interrupt income flow addresses the situation where an obligor under a support or alimony order is unable to pay because of a medical problem. That section reads,

> Was a member of the household in which one or more members (including the debtor) lost all or substantially all of the member's alimony or support income for four or more weeks

during such 12 month period due to a medical problem of a person obligated to pay alimony or support.

The fact that two of the three definitions of "medically distressed debtor" are centered upon interrupted income demonstrates that the drafters of H.R. 901 fully appreciated the havoc which a medical condition can cause by disrupting the debtor's income.

Having recognized the financial distress caused by medical conditions, H.R. 901 offers significant protection to the debtor who must turn to bankruptcy for relief. The centerpiece of H.R.901 is enhancing and assuring availability of a meaningful homestead exemption to any medically distressed debtor seeking bankruptcy protection. To appreciate the value of this amendment, it is necessary to understand how a homestead exemption works. As a general matter, federal and state exemption laws have the objective of assuring that individuals in serious financial trouble are not deprived of the bare essentials of life through the debt collection process. Most exemptions recognize and protect the value of basic essentials needed by families to maintain a subsistence standard of living. Typically such exemptions protect modest amounts of household furniture, appliances, an automobile, tools of the trade, beds, bedding and clothing of the debtor and family. These exemptions assure that the debtor will come through the collection process, including bankruptcy, with at least the basic necessities from all the possessions that the debtor may have acquired over a lifetime. The existence of these exemption laws reflects a policy decision by state legislatures and Congress that, in the competition between the claims of unsecured creditors and the basic well-being of the debtor and family, no individual will be deprived of the basic necessities. These policies also advance the important objective of preventing debtors from becoming public charges, unable to maintain themselves without assistance from the government.

Probably the most important exemption is the "homestead" exemption. "Homestead" generally refers to the dwelling house in which the family lives, as well as enough of the surrounding land to enable a family to make effective use of the property. The homestead exemption may be a unique American phenomenon as it was widely adopted throughout the country during the 1800's to encourage westward migration and settlement. Colonial Texas (under Mexican rule) had one of the earliest homestead provisions in 1829. Georgia and Mississippi became the first US states to follow Texas's lead and enact their own homestead exemptions. An economic downturn – the Panic of 1837 – hit the South particularly hard. Homestead exemptions were adopted in the South as a way to dissuade residents from abandoning that region to make a fresh start in Texas, but also as a way to curb the destructive impacts of the free market by protecting families against financial destitution. Support for these new exemptions crossed party lines. The mass appeal of this unique form of protection led 10 of 14 Southern states to pass their own homestead laws as early as 1859.

Outside the South, the homestead exemption movement also began gathering momentum by midcentury. By 1852, all the northeastern and mid-Atlantic states (with the exception of Delaware, Rhode Island, and Maryland) exempted at least $300 of a homestead from the reach of creditors. Every single mid-western state and territory passed a similar provision by 1858. Alison D. Morantz, THERE'S NO PLACE LIKE HOME: HOMESTEAD EXEMPTION AND JUDICIAL CONSTRUCTIONS OF FAMILY IN NINETEENTH-CENTURY AMERICA, 24 Law & Hist. Rev. 245 (2006)

In colonial times the homestead protection recognized the economic reality that many families made a living or produced food from working the land. Modern statutory homestead exemptions focus primarily on preserving shelter for the family in the dwelling in which they have demonstrated an intent to reside.

The National Consumer Law Center has summed up the utility and value of the homestead exemption in the following excerpt from its manual, Collection Actions – Defending Consumers and their Assets, First Edition (2009), page 275-276.

> Homestead exemptions are designed to protect the home for the debtor and the debtor's family. The only states that do not provide for homestead exemptions are Delaware, Maryland, New Jersey, and Pennsylvania. The remaining states each set a different amount that is exempt. For example, New Hampshire allows $100,000; New York allows $50,000; Florida does not set a dollar amount but allows up to 160 acres outside a municipal area and a half acre within a municipal area. Some states provide a larger homestead exemption for elderly or disabled persons. When a statute caps the value of an exempt parcel of land, but not its acreage, there is no limit on the size of the parcel.
>
> The dollar amount of the homestead exemption generally refers to the debtor's equity of the property. For example, if a $200,000 property is encumbered by $190,000 mortgage then a $10,000 homestead exemption will make it completely exempt. If the area or value of the homestead exceeds the statutory limit and division is not feasible, for example, a quarter acre homestead in a suburb with one acre zoning, the homestead may be sold and the debtor will receive the exempt amount.

Because the homestead right is purely a creature of statute, it is necessary to consult the law of the state where the property is located to determine the extent of the homestead protection. Generally, the homestead exemption protects the family which lives in the home and claims it as their primary residence from loss of property to the claims of creditors whether advanced through litigation or other process. Generally an unsecured creditor would be unable to execute on the property by exposing it to sheriff's sale if the scope of the homestead protects the entire interest of the family in that property. The public policy behind the homestead is to promote stability and the welfare of the community by encouraging property ownership and independence on the part of homeowners. While creditors may obtain a judgment against the property owner, that judgment usually may not be enforced against that part of the property or value of the property which is protected by the homestead right. In colonial times it often meant that the executing sheriff would set off a certain part of the homestead to assure that the family retained

shelter and enough land to continue supporting itself or producing food. Today the homestead right is usually recognized as a dollar amount. In the execution process the homeowner will be entitled to a cash payout from the proceeds of any sale with the idea that the cash recovered can be used to reassert or reestablish a new homestead after the family moves on. In cases where the value of the homestead is large enough, pursuing a sheriff sale may prove futile and this reality has the effect of preserving the homestead for the family[1].

H.R. 901 would boost the homestead exemption for "medically distressed debtors" seeking bankruptcy protection to $250,000. This enhanced homestead would be available to debtors invoking either the federal exemptions or a particular state's exemption. What class of debtors would most benefit from this expanded protection? As a practical matter this provision would have no effect upon those people whose mortgage debt exceeded the value of their property. Because such borrowers would have waived their homestead exemption for the benefit of the mortgage company, the loss of their home through foreclosure would include loss of the homestead. In such cases the existence of the $250,00 homestead exemption would be unavailing.

However, if we consider the plight of the elderly couple who had managed to pay off the mortgage on the family home over many decades of hard work, the availability of the $250,000 homestead exemption would be of the utmost significance. Such a debtor could invoke the

[1] It should be pointed out that when a homeowner grants a mortgage to a lender to acquire property or refinance an existing loan, the lender always requires the borrowers to waive all homestead rights as to that creditor. Thus, the many individuals facing the loss of their homes through foreclosure may not avail themselves of the homestead protection because that right was waived at the closing table when the loan papers were signed.

statutory exemption contemplated by H.R. 901 and thereby preserve a significant amount of the equity in their home. This preservation of the homestead would be completely consistent with the goal of bankruptcy to provide a fresh start to the debtor. It would also prevent individuals and families from becoming homeless in spite of unanticipated financial calamity. To benefit from this protection, the medically distressed debtor would have to have significant equity in the home. This is usually the case with elderly individuals or couples who have prudently paid off their mortgages over the years.

Beyond preservation of the home, homestead exemption may also be useful in enabling a medically distressed debtor with a generous amount of home equity to pursue a chapter 13 payment plan. Such a debtor might well be ineligible to file a Chapter 13 plan because they would not be able to satisfy the liquidation test which must be addressed in every Chapter 13. The liquidation test requires the debtor to demonstrate that the unsecured creditors would receive more through the Chapter 13 payment plan than would be realized if the debtor simply liquidated all non-exempt property through a Chapter 7 filing. By exempting a significant part of the equity of the elderly couple's home from the bankruptcy estate, the debtor could satisfy the liquidation test and achieve a more affordable payment plan. In those cases where the debtor simply elected to liquidate through Chapter 7, the objectives of the fresh start would be realized by preserving the value of the homestead for the debtor and family. In either case the debtor will be in a better position to realize a fresh start and to avoid the specter of homelessness. Such a result is consistent with the public policy of stabilizing families and communities by preserving the essentials a family requires, including the family homestead.

Conclusion

H.R. 901 is narrowly drafted to benefit a very deserving class of medically distressed debtors forced to seek bankruptcy protection because of unanticipated or prolonged medical conditions and overwhelming medical debt. To realize the intended benefit of the enhanced homestead protection, such debtors must have accumulated significant equity in their homes. Such debtors are usually elderly or retired individuals who prudently managed their financial affairs, avoided the temptations of refinancing to enhance their lifestyles or otherwise engaged in reckless borrowing. Their downfall was usually caused by tragic occurrence of a medical catastrophe which interrupts income flow and saddles them with unmanageable medical debt. It is consistent with the well recognized policy within the American bankruptcy system that such debtors be afforded a fresh start and the ability to preserve their homesteads. Because H.R. 901 creates critical protection to achieve these important objectives, it should be added to our existing bankruptcy law.

Mr. COHEN. Thank you very much.

I want to thank all our witnesses for their testimony, and I will start with the questions.

And first of all, Professor Wright, I would like to ask you what your thoughts are on the means test.

Mr. WRIGHT. Well, generally or as it applies to this 901?

Mr. COHEN. As it applies to this bill.

Mr. WRIGHT. So as——

Mr. COHEN. Dr. Mathur made a point that possibly high-income individuals could get away with things. Is there a way to see to it that high-income individuals don't and that it is strictly tailored to medical bills?

Mr. WRIGHT. If we viewed 901 as a whole and appreciate that the only way the homestead exemption benefits a debtor is if that debtor has substantial equity in their house, you are going to eliminate a lot of debtors right off. You are going to eliminate all the debtors who use their homes as ATM machines, so-called during the bubble, those who did practice abusive borrowing.

You are really going to be targeting and benefiting elderly people, who worked their whole life to pay off their mortgages and then as they approach their retirement, they simply want to be able to hold onto their homestead. Those debtors who then face a catastrophic illness, which interrupts their income or saddles them with medical debt, will be able to retain their home. They don't need to be tested under the means test, because they are not gaming the system.

To be the victim of a medically—well, as someone, I think, the Chairman may have put it—the medically lost life lottery to be suddenly stricken with a serious medical illness is not part of gaming the system. They don't need to be means tested.

Mr. COHEN. Thank you, Dr. Wright.

Dr. Mathur, let me ask you this. As Professor Wright has mentioned and I have said before, the lottery of life, the people that have these great health care disasters, catastrophic illnesses, is that it just happens. It is, most cases, not just unfortunate.

Do you agree that some people who get catastrophic illnesses—cancers, heart disease, whatever—end up getting massive medical debt that causes some people to go into bankruptcy?

Ms. MATHUR. Absolutely. I absolutely agree that there are people with medical debt who will go into bankruptcy, and I believe that the current bankruptcy code in fact allows those low-income debtors to take advantage of the bankruptcy filing.

Mr. COHEN. Those who, debtors?

Ms. MATHUR. The low-income.

Mr. COHEN. What if you are not low income, but you got cancer and you have been wiped out?

Ms. MATHUR. And then if the means test shows that you still have an ability to repay some part of your debt, then I believe that the current bankruptcy system will——

Mr. COHEN. So you don't believe if you have got tremendous medical debt and you are a middle-class person and you have got some income, but you have got enormous debt, hundreds of thousands of dollars worth of debt, and you have got cancer and maybe, you know, maybe you potentially lose your job, that there shouldn't be relief somehow fashioned for you?

Ms. MATHUR. I think the chapter code redeeming procedure allows for the medical expenses to be deducted in calculating what your ability to repay is, so I don't see what the new act is trying to achieve by saying that we should not have means testing at all.

Mr. COHEN. Judge Morris, can you explain why that is important that we give some relief to people who have been wiped out because of the lottery of life?

Judge MORRIS. I think this is hard for me to explain. And I have been listening to the means test question here. And once upon a time before 2005, you wouldn't confirm a Chapter 13 plan unless the unsecured creditors were going to get a substantial amount. Now you confirm a .003, which is basically a Chapter 7. And the reason you do it is for some of the matters that they talked about.

You know, I see the medical people in—the medical debtors in front of me all the time. They walk in. In my testimony I talk about the five—my written testimony—my courtroom deputy coming in to me and saying, "It is going to be a hard day today, Judge." "Why is it going to be hard today?" "There are five women in the courtroom with turbans on. Your Honor, you are going to have to hear the story of those five cancers." And sure enough, I have to hear the story of the five cancers.

The means test is simply meant that it moves them to Chapter 13. It just simply means that it is more expensive for them to file. Those people needed—most of those people need to be in 7. They need to be able to get rid of some debt and move on.

We are in a wonderful place in this world, in this country, in this here that we have the ability to file bankruptcy, that we have an ability to start anew. And sometimes we need to just take and look, and they need to be able to cut their losses and move on.

I don't agree that—the means test is just more expensive. It just makes it more difficult for them to come in and forgive the debt and move on.

Mr. COHEN. Thank you, Judge.

Dr. Mathur, are you familiar with the study by Melissa Jacoby and Miyra Holman published in the Yale Journal that debunks the 2005 Department of Justice survey that you have in your written testimony?

And being familiar with it, do you still hold to your belief that this 2005 DOJ study has validity?

Ms. MATHUR. I think the Jacoby study tries to say that there could be a lot of hidden medical debt that you are not actually observing in the bankruptcy filing. And that, you know, that is entirely possible, and we have debated that issue a lot of times.

So that is why it makes more sense to not sort of rely on just those kind of, you know, bankruptcy statistics, but to actually see what household surveys are saying about medical debt and how, you know, what is really happening to medical debts over this period.

And there is nothing to suggest that there has been, you know, that tremendous a jump that, you know, medical bankruptcies should have risen by 50 percent in the 7-year period, because if that had really been the case, then when bankruptcies went up, you should have seen a tremendous increase in the medical debts as well, which you don't see.

So I completely agree that there could be problems with the DOJ study, but that doesn't deny the fact that they—you know, that neither of those studies has conclusively proven that medical debts are a significant fraction of all bankruptcies.

Mr. COHEN. Thank you, Doctor.

Mr. Franks, you are recognized.

Mr. FRANKS. Mr. Chairman, could I pass on to Mr. Coble for his questions?

Mr. COBLE. I thank the Ranking Member, thank the Chairman. Good to have you all with us today.

Dr. Mathur, this is not unlike much proposed legislation. There are loopholes. What loopholes do you think are most unfair in this bill?

Ms. MATHUR. I think the biggest loophole in the bill is the requirement to do away with the means test, because I think the reason we had the means test instituted in 2005 was because we saw a lot of instances where people were exploiting the system by having a lot of wealth in their homes, having a lot of incomes, but they had the choice to still file under Chapter 7 bankruptcy and have their, you know, million-dollar debts paid off and still retain a million-dollar house.

And so I think the biggest loophole that could be exploited under the Medical Bankruptcy Fairness Act is the fact that high-income debtors could take advantage of the system to basically have the same provisions that they had before 2005, which is, you know, you accumulate a certain amount of medical debt and you still get all the advantages of Chapter 7.

I think if we had a system where we said you could only do away with the medical debts by filing under Chapter 7, then, you know, I think that would correct some of these loopholes.

Mr. COBLE. I thank you, Doctor. It seems to me that this—I will qualify this is my opinion—I think Obamacare has failed its stated goal of decreasing health care costs and probably will in fact increase health care cost. Given the incentives in H.R. 901, will this bill not increase health care costs, making the health care system perhaps even more unsustainable?

Ms. MATHUR. Yes, I think that any time we sort of—if we think that we are going to keep absorbing the cost of all these unpaid debts, you know, infinitely into the future and that it is not going to have an impact on how people behave and how creditors and how lending markets behave, then, you know, you are wrong.

At some point all of these unpaid debts and all of these, you know, huge costs that we think we are subsidizing, at some point they are going to tremendously increase costs on borrowers.

Mr. COBLE. Your Honor, Chapter 7's means that there was never intent to inquire into whether the causes of someone's bankruptcy were either good or bad, it seems to me——

Judge MORRIS. Right.

Mr. COBLE [continuing]. But simply whether the debtor had the income sufficient to repay a substantial or meaningful portion of unsecured debt.

Do you believe—well, strike that. It is my belief, and I will ask you if you believe this, that Congress may be opening a Pandora's box if it started to pursue down that path of choosing which kinds of debt are "good" or which kinds of debt are "bad." What do you say to that?

Judge MORRIS. I don't disagree with you, but I think the door that opened in 2005, and I think this might go some ways to helping some people that need the help.

Mr. COBLE. I thank you both.

And, Professor, I don't want to ignore the gentleman from New England. My favorite New England state, by the way, Professor, is New Hampshire. Professor, do you have the fear that abusive filings might promote or distract from the court's ability to process promptly the cases of the truly needy—that is, those who may abuse it?

Mr. WRIGHT. Well, I think that abusive filings are never good for the system, but I don't believe abusive filings will be any easier if H.R. 901 were to pass because of the way it is drawn.

Mr. COBLE. Dr. Mathur, do you want to weigh into that?

Ms. MATHUR. I am not clear why it would not, because, I mean, the fact that you are doing away with the means test does mean that there would be high-income people with the ability to repay, who you are now saying should be excused from using them.

Mr. WRIGHT. The reason I think that the chances are very low is because, at least from my experience, when a family or an individual bases one of these catastrophic injuries that interrupt income flow, you no longer have a high-roller high-wage earning debtor.

They—in my cases, in fact—I mean, I don't want to say in all cases they are going to pass the means test, but given the way we calculate current monthly income by looking at the last 6 months, if there has been a tragic and unanticipated medical problem, whether it is an injury or a disease, a lot of times the income is so disrupted that the means test isn't really going to be an issue.

Mr. COBLE. I got you. Thank you, Professor.

Mr. Chairman, I want you to note that the red light has illuminated, and I am yielding back.

Mr. COHEN. Thank you, Mr. Coble. I appreciate your continual courtesies.

Now the Chairman, Mr. Conyers, is recognized.

Mr. CONYERS. Thank you.

I would like to ask Dr. Aparna Mathur if when Professor Wright was giving his explanation about the nature of medical indebtedness, did he say anything that disturbed you or that you didn't agree with?

Ms. MATHUR. I think the kind of examples that Professor Wright gave would typically file under Chapter 7 bankruptcy, and they would meet the means test. But they are the kind of people that he was speaking about with no incomes, who have mainly had a catastrophic, you know, medical expense.

You know, from all that I think I understand about how the bankruptcy code currently works, those people should meet the means test, and they should be allowed to file under Chapter 7.

The people who will not meet the means test are people who do have an ability to repay, and I think that they—you know, the current system, the way it is functioning would—you know, should make them repay a part of those debts. I don't see why we need to do away with that particular feature of the current code.

Mr. CONYERS. Professor Wright, did she accurately interpret your examples?

Mr. WRIGHT. Yes, I think she is right. In all three of those cases, those individuals would not have a problem with the means test. In fact, in the very first one with the car accident, we put them into Chapter 13 to save his home. So even though he passed the means test as consumer bankruptcy lawyers say, meaning he wasn't forced to go into Chapter 13, he voluntarily went into 13 to catch up on a delinquent mortgage and to save his home.

So, yes, she did accurately gauge the impacts, at least on those three cases. They would not have been—they would not have been caught up or forced to file a different chapter than they chose.

Mr. CONYERS. Well, does that mitigate your examples, then?

Mr. WRIGHT. No, because the examples—well, I unfortunately—I don't have an example of a high-roller who suffers a major medical calamity and then runs up against the means test, partly because my clinic only represents low-income people. I mean, we are not allowed to represent the high-rollers or just the upper middle class, because we don't do that.

But I really—I still—when I studied this in preparation for coming down here, I don't really understand all the fuss about the means test, to tell you the truth, because I really think that people who are overtaken by one of these terrible medical tragedies, if they had any inclination to game the system, their fight for their lives or for that of a family member becomes paramount in their minds.

And it certainly would be more convenient for them if they didn't have to go through all the paperwork that Judge Moore spoke about and the added expense that lawyers are able to charge because of the paperwork. But given that they may very well lose their income as their sole—they are just so fixated, and their attention and thought is all devoted to obtaining a cure, I think the gaming question is really irrelevant at that point.

And I also have to say that I don't think that—I just don't quite understand how someone can game or contrive or conjure up medical bills to try to invoke this as a way to game the system. I mean, even at the level of $10,000, that is a little hard to envision, frankly.

Mr. CONYERS. Do you agree, Dr. Mathur, with what the professor said?

Ms. MATHUR. I don't believe that people can conjure up medical bills, but I do believe that you could create the incentive that if you had medical debt and you had other kinds of debt, that the incentive to sort of accumulate the medical debt and not pay it off and pay off the other kinds of debt, you might perverse those kinds of incentives, because you know that if you had a certain amount of medical debt, then your lawyer would tell you, "Well, you know, if you had so much in medical debt, then you could take advantage of Chapter 7."

So a person who—I am not saying that they are going to conjure up an illness, but you could change incentives for them by saying, you know, if you had so much in medical debt, then, you know, you can take advantage of all the Chapter 7 exemptions and the high

exemptions and the debt discharge that comes with that. Those are the kinds of incentives that I am talking about.

Mr. CONYERS. That does not sound persuasive to me.

Judge Morris, what is your experience in this area?

Judge MORRIS. Well, as I am listening, the one thing I am thinking is now we have it, a system where the medical debt is hidden as credit card debt or second mortgages, because the one thing you want to do is not go bankrupt against your doctor, because you will be fearful that the doctor will not treat you.

Mr. CONYERS. Of course.

Judge MORRIS. So right now the debtors come in, and they paid the medical bill with—their co-pays with the credit card. They have paid it by taking out the second mortgage.

I had personal experience of a dear friend who lost his wife to cancer. It was the secondary cost, too. Tell me, anybody, if you have a family member that needs a heating pad, if you have a family member that needs a humidifier, and in the mail comes your checks, those little credit card checks, that is not going to be attributed to medical bills.

So when I hear this talking about that they will now run up a medical bill as opposed to a credit card bill, when in fact it has been the opposite right now, where they have been running up a credit card bill in order to maintain the medical care for their family, it just seems unconscionable to me.

Let us have a real—let us have a real reason for the bankruptcy. And if the real reason for the bankruptcy is a medical catastrophe, then why not give people like that in those situations a break?

Mr. CONYERS. Do you agree, Dr. Mathur?

Ms. MATHUR. I think that it all comes down to how would you in your bankruptcy—Medical Bankruptcy Fairness Act define what is a medical debt. I mean, it is then we need the act to be clearer on what you are saying——

Mr. CONYERS. There is no question about what constitutes a medical debt.

Ms. MATHUR. Yes, but that is what Judge Morris just said, that we cannot distinguish between credit card debt and medical debt. And so if that happens to be the problem, then you are going to see $10,000 in credit card debt, and you won't know if it is——

Mr. CONYERS. But that is the problem. That is what she is saying. The medical debt is hidden by using your credit cards.

Ms. MATHUR. Yes. And so how would you——

Mr. CONYERS. So don't you agree with her? Or you don't agree with her.

Ms. MATHUR. So what I want to know is if there is——

Mr. CONYERS. Do you agree or not with her?

Ms. MATHUR. Yes, there is some medical debt on credit card debt. Absolutely.

But even if you are saying that that is—I mean, there are two issues. If you are saying that, you know, that debt has somehow been going up and that is causing the bankruptcy, there are no data to support that either, because even if you look at total credit card debt, that has gone up by .3 percentage points between 2000 and 2007.

The other issue is if we say that, you know, is credit—are we going to sort of try to uncover all the medical debt that people have on credit cards and, you know, is the second mortgage really a form of medical debt, then the act needs to be clear on what all it is going to—you know, how are we going to distinguish all the sources of medical debt rather than just what we see as a medical bill.

Mr. CONYERS. Well, Professor Wright was complementing our drafters on putting together a proposed piece of legislation that does take care of some of that problem.

Isn't that right, Professor?

Mr. WRIGHT. Yes. Yes, I think that the—when I sat down and carefully studied the act, I was impressed by how thoroughly the drafters understand the problem of medical catastrophe first and then applied it to the plight of debtors.

So you covered all the possibilities—massive debt, then prolonged interruption of income from earnings, and finally interruption of child support, alimony and support, the domestic support obligations, as they are called. So you covered all the main drivers that force people into bankruptcy when they have lived through or are living through catastrophic medical problems.

Mr. CONYERS. Dr. Mathur, do you agree more with Judge Morris or Professor Wright?

Ms. MATHUR. I have problems with both.

Mr. CONYERS. You probably agree with some of both, what both are saying.

Ms. MATHUR. I think that if you prove that that actually drove the bankruptcy, then we have the case that we have a medical bankruptcy.

If, like in this Himmelstein study, we simply found that someone reported that at some point in the previous 2 years we had, you know, a week's worth of lost, you know, work, and then we say, "Okay, that is a medical debtor and that is a medical bankruptcy," then that is overstating the problem.

I think if we had a way, a convincing way of showing that, you know, this is what drove the person to bankruptcy, then I would agree with Professor Wright.

Mr. CONYERS. Well, all you have to do is show that their medical debt is on the credit card and that—what else—what more would you need?

Ms. MATHUR. Pardon me?

Mr. CONYERS. What else would you need to prove what the real costs of the—the real reason for the credit card indebtedness was because of medical bills?

Ms. MATHUR. Yes, if you can show that the credit card——

Mr. CONYERS. It is easy. All you do is read. It says it is from X hospital.

Ms. MATHUR. Yes, I understand that.

Mr. CONYERS. $20,000. You don't need any more than that, do you?

Ms. MATHUR. Yes, that is absolutely credible. Yes.

Mr. CONYERS. Well, then you agree with both Morris and Wright.

Ms. MATHUR. I agree that if we could have a procedure for determining exactly where the debt was. So, for instance, she said if——

Mr. CONYERS. It is easy. You have to identify. On a credit card you have to—when you are going into bankruptcy, you have got to identify where the indebtedness came from.

Ms. MATHUR. Right.

Mr. CONYERS. You got to name it. You can't just say $150,000 worth of debt. They are saying, "What debt?" Well, when you see it is from doctors, clinics and hospitals, that is pretty obvious where it came from.

Ms. MATHUR. I completely agree with that. I think if you had a certain way you could make the debtor show that there was so much medical debt on credit cards, then that is exactly the way to show how much medical debt you had. But if you say, "Oh, I took out a second mortgage because of this," or "I did"—you know, if there is no way of actually tracking it, then I don't think——

Mr. CONYERS. But there is a way. When you go in—have you—are you familiar with—well, no, you are not a lawyer. You are an economist.

Professor Wright?

Mr. WRIGHT. Well, the fact is on Schedule F of the official forms, which every debtor must fill out, there is a column as part of the description of unsecured debt where the debtor is required to say what was the debt for.

So if you have a $15,000 charge because you paid a clinic, it should say Capital One or Visa, and then the consideration for the debt is where you would state this was for the clinic or the hospital for whatever the care was, and then the total. So there is provision currently in the official forms for revealing that information.

Mr. CONYERS. You should know, Dr. Mathur, that there is no way you can go through a bankruptcy proceeding without identifying the source of your indebtedness.

Ms. MATHUR. I thought that was the point that Judge Morris was making, that there is so much debt on credit cards, there is so much, you know, other kinds of debt that is arising because of medical illnesses that we are not able to track.

If that was the point that she was making, then, you know, that is what I thought she was making. If you are saying that we can track medical debt on credit cards, then you can easily——

Mr. CONYERS. Well, you can. And they do.

Ms. MATHUR. Exactly.

Mr. CONYERS. That is the only way they can pay it.

Ms. MATHUR. Exactly.

Mr. CONYERS. Because they don't want to——

Ms. MATHUR. Then I think the best——

Mr. CONYERS [continuing]. They don't want to name——

Ms. MATHUR. Then I think——

Mr. CONYERS [continuing]. They don't want to——

Ms. MATHUR. And I think that the best modification you could make to the act would be to say that you would only forgive the medical debt under Chapter 7, because if you are trying to help medical debtors, then that is exactly what you want to do.

Mr. CONYERS. But sometimes you go into a different form of bankruptcy, because you don't want to lose your house. That is what Professor Wright was saying.

Professor Wright, as I close down, do you know how many pages this—that is in a statement, a means test? Have you seen this?

Mr. WRIGHT. I am familiar with the——

Mr. CONYERS. No, I mean have you read it?

Mr. WRIGHT. No.

Mr. CONYERS. This is more complicated than the average income tax form.

Mr. WRIGHT. Oh, you are just speaking about the code itself?

Mr. CONYERS. No, I am speaking about the means test—Form 22A.

Mr. WRIGHT. Yes, in fairness and so the Committee is fully apprised, most bankruptcy practitioners use software, which greatly eases. To draw a rough analogy, it is like the difference between filling out the IRS forms for your taxes and using TurboTax. There are fields that you can fill in, which does ease—just so you know, it does ease the burden of that. So it is not as onerous as you might think, looking just at the——

Mr. CONYERS. Yes, but suppose a person going into bankruptcy can't afford that?

Mr. WRIGHT. Well, that is true. Or if they can't afford the lawyer, who has the software——

Mr. CONYERS. Exactly.

Mr. WRIGHT [continuing]. And they don't have a clinic like mine that does it for free, yes, that is a problem. That has been a problem with the means test all along.

Mr. CONYERS. May I give you this form as a thank you for coming before the Committee and invite you to read it? To me it is very complicated. Now, to tell me that, "Don't worry. Your lawyer has a computerized form to expedite this" is—most debtors can't afford that.

Am I incorrect, Judge Morris?

Judge MORRIS. Not only can most debtors not afford it, I think it can be discouraging, if you do not have an attorney. If they start reading it, it is more difficult than the income tax return, as you said, so it is very discouraging. So if you don't have an attorney that says, "I understand this. Let me walk you through it," then you are discouraged.

And if you add on top of that someone that is going through a medical catastrophe that has to file insurance forms, which we all know are also complicated——

I mean, I have the same insurance you do. My insurance is good. And yet I get turned down. Right. And I call them up. We are blessed. I get to pick them up on the—and honestly, when they changed my first name to Judge, people answer the phone a little quicker. Well, not everybody has that asset. But even I, when I have to go through all the medical insurance forms, find that difficult.

So in the middle of trying to heal, in the middle of going to chemotherapy or going to physical therapy or going to the doctor, and like I had in front of me not this past week, but a month ago, where their child was dying, and I was insisting that somebody come to court not knowing that a child is dying, they have to go through that test, appear at the first meeting of creditors, have the

U.S. trustee try to decipher are not whether or not they are abusive, and do all of that at the same time.

I think there is something going on at the table here, though, that I think I just need to give a little insight from me. Dr. Mathur talked about lending markets and credit markets.

Professor Wright and I are the boots on the ground. We look in the eyes of the people that are filing. We don't look at statistical data. We see what comes in front of us. We can't look at statistical data. That is not our job. Our job is to deal with the case that is in front of us and the people that come before us asking for relief.

By its very definition, bankruptcy has to do with the debtor. Yes, we are fair to creditors. Yes, we listen to creditors. Yes, we follow the law. That is what we are sworn to do, and we do it. But by definition we are looking at those debtors, and we see them eyeball-to-eyeball.

Mr. CONYERS. Thank you, Judge Morris, because you reminded me. Heaven help the poor debtor that goes into a law office where the lawyer is not familiar with bankruptcy proceeding.

Judge MORRIS. Yes. Exactly.

Mr. CONYERS. And I think——

Judge MORRIS. I just asked for the license of two New York State people because of what they did to debtors by not knowing bankruptcy law.

Mr. CONYERS. Yes.

Thank you, Mr. Chairman.

Mr. COHEN. Thank you, Mr. Conyers.

And we will now recognize Mr. Franks, and we will do these 5 minutes. We have votes coming up, and we should——

Mr. FRANKS. I will stick to the 5 minutes, I promise.

Mr. Chairman, I just wanted to just out of courtesy here, not trying to prove any special point, but I had mentioned in the opening statement that 53 percent or a majority was in favor of the repeal of Obamacare, and this is a Rasmussen poll done on—it came out July 12th, just a few days ago. And 53 percent of the voters nationwide favor the repeal of the recently passed national health care law.

And I don't say that to prove anything, because I don't think we should base policy on polls. I just wanted you to know that I was being forthright when I mentioned that statistic to you.

And also, Mr. Chairman, I am hoping that I can put into the record the Obama administration report confirming that the health care law actually increased the health care spending. And I will ask it to be placed in the record.

Mr. COHEN. Without objection.

[The information referred to follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop N3-01-21
Baltimore, Maryland 21244-1850

Office of the Actuary

DATE: April 22, 2010

FROM: Richard S. Foster
Chief Actuary

SUBJECT: Estimated Financial Effects of the "Patient Protection and Affordable Care Act," as Amended

The Office of the Actuary has prepared this memorandum in our longstanding capacity as an independent technical advisor to both the Administration and the Congress. The costs, savings, and coverage impacts shown herein represent our best estimates for the Patient Protection and Affordable Care Act. We offer this analysis in the hope that it will be of interest and value to policy makers and administrators as they implement and monitor these far-reaching national health care reforms. The statements, estimates, and other information provided in this memorandum are those of the Office of the Actuary and do not represent an official position of the Department of Health & Human Services or the Administration.

This memorandum summarizes the Office of the Actuary's estimates of the financial and coverage effects through fiscal year 2019 of selected provisions of the "Patient Protection and Affordable Care Act" (P.L. 111-148) as enacted on March 23, 2010 and amended by the "Health Care and Education Reconciliation Act of 2010" (P.L. 111-152) as enacted on March 30, 2010. For convenience, the health reform legislation, including amendments, will be referred to in this memorandum as the Patient Protection and Affordable Care Act, or PPACA.

Included are the estimated net Federal expenditures in support of expanded health insurance coverage, the associated numbers of people by insured status, the changes in Medicare and Medicaid expenditures and revenues, and the overall impact on total national health expenditures. Except where noted, we have not estimated the impact of the various tax and fee provisions or the impact on income and payroll taxes due to economic effects of the legislation. Similarly, the impact on Federal administrative expenses is excluded. A summary of the data, assumptions, and methodology underlying our national health reform estimates will be available in a forthcoming memorandum by the OACT Health Reform Modeling Team.

Summary

The table shown on page 2 presents financial impacts of the selected PPACA provisions on the Federal Budget in fiscal years 2010-2019. We have grouped the provisions of the legislation into six major categories:

(i) Coverage provisions, which include the mandated coverage for health insurance, a substantial expansion of Medicaid eligibility, and the additional funding for the Children's Health Insurance Program (CHIP);

(ii) Medicare provisions;

(iii) Medicaid and CHIP provisions other than the coverage expansion and CHIP funding;

(iv) Provisions aimed in part at changing the trend in health spending growth;

(v) The Community Living Assistance Services and Supports (CLASS) program; and

(vi) Immediate health insurance reforms.

The estimated costs and savings shown in the table are based on the effective dates specified in the law as enacted. Additionally, we assume that employers and individuals would take roughly 3 to 5 years to fully adapt to the new insurance coverage options and that the enrollment of additional individuals under the Medicaid coverage expansion would be completed by the third year of implementation. Because of these transition effects and the fact that most of the coverage provisions would be in effect for only 6 of the 10 years of the budget period, the cost estimates shown in this memorandum do not represent a full 10-year cost for the new legislation.

Estimated Federal Costs (+) or Savings (−) under Selected Provisions of the Patient Protection and Affordable Care Act as Enacted and Amended
(in billions)

	Fiscal Year										Total,
Provisions	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-19
Total*	$9.2	$0.7	−$12.6	−$22.3	$16.8	$57.9	$63.1	$54.2	$47.2	$38.5	$251.3
Coverage†	3.3	4.6	4.9	5.2	82.9	119.2	138.2	146.6	157.6	165.8	828.2
Medicare	1.2	−4.7	−14.9	−26.3	−68.8	−60.3	−75.2	−92.1	−108.2	−125.7	−575.1
Medicaid/CHIP	0.9	−0.9	0.8	4.5	8.6	5.1	4.6	3.4	1.3	1.7	28.3
Cost trend‡	—	—	—	—	−0.0	−0.1	−0.2	−0.4	−0.6	−0.9	−2.3
CLASS program	—	−2.8	−4.5	5.6	−5.9	−6.0	−4.3	−3.4	−2.8	2.4	−37.8
Immediate reforms	5.6	3.2	1.2	—	—	—	—	—	—	—	10.0

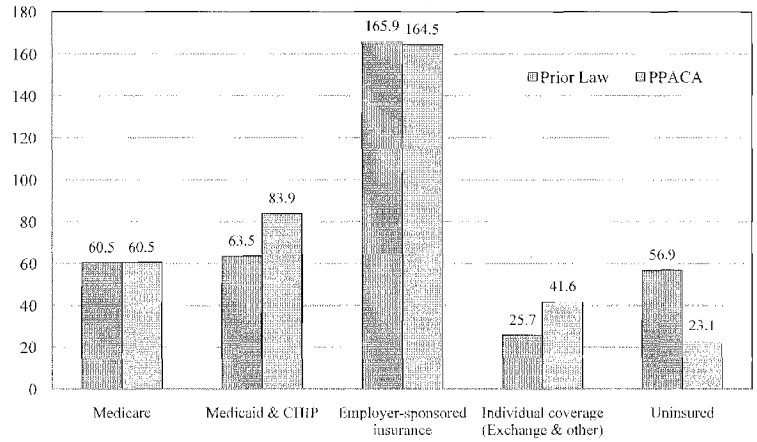
* Excludes Title IX revenue provisions except for sections 9008 and 9015, certain provisions with limited impacts, and Federal administrative costs.
† Includes expansion of Medicaid eligibility and additional funding for CHIP.
‡ Includes estimated non-Medicare Federal savings from provisions for comparative effectiveness research, prevention and wellness, fraud and abuse, and administrative simplification. Excludes impacts of other provisions that would affect cost growth rates, such as the productivity adjustments to Medicare payment rates (which are reflected in the Medicare line) and the section 9001 excise tax on high-cost employer plans.

As indicated in the table above, the provisions in support of expanding health insurance coverage (including the Medicaid eligibility changes and additional CHIP funding) are estimated to cost $828 billion through fiscal year 2019. The Medicare, Medicaid, growth-trend, CLASS, and immediate reform provisions are estimated to result in net savings of about $577 billion, leaving a net overall cost for this period of $251 billion before consideration of additional Federal administrative expenses and the increase in Federal revenues that would result from the excise tax on high-cost employer-sponsored health insurance coverage and other revenue provisions. (The additional Supplementary Medical Insurance revenues from fees on brand-name prescription drugs under section 9008 of the PPACA, and the additional Hospital Insurance payroll tax income under section 9015, are included in the estimated Medicare savings shown here.) The Congressional Budget Office and the Joint Committee on Taxation have estimated that the total net amount of Medicare savings and additional tax and other revenues would

somewhat more than offset the cost of the national coverage provisions, resulting in an overall reduction in the Federal deficit through 2019.

The following chart summarizes the estimated impacts of the PPACA on insurance coverage. The mandated coverage provisions, which include new responsibilities for both individuals and employers, and the creation of the American Health Benefit Exchanges (hereafter referred to as the "Exchanges"), would lead to shifts across coverage types and a substantial overall reduction in the number of uninsured, as many of these individuals become covered through their employers, Medicaid, or the Exchanges.

Estimated Effect of the Patient Protection and Affordable Care Act, as Enacted and Amended, on 2019 Enrollment by Insurance Coverage
(in millions)



Note: Totals across categories are not meaningful due to overlaps among categories (e.g., Medicare and Medicaid).

By calendar year 2019, the mandates, coupled with the Medicaid expansion, would reduce the number of uninsured from 57 million, as projected under prior law, to an estimated 23 million under the PPACA. The additional 34 million people who would become insured by 2019 reflect the net effect of several shifts. First, an estimated 18 million would gain primary Medicaid coverage as a result of the expansion of eligibility to all legal resident adults under 133 percent[1] of the Federal Poverty Level (FPL).[2] (In addition, roughly 2 million people with employer-

[1] The health reform legislation specifies an income threshold of 133 percent of the Federal Poverty Level but also requires States to apply an "income disregard" of 5 percent of the FPL in meeting the income test. Consequently, the *effective* income threshold is actually 138 percent of the FPL. For convenience, we refer to the statutory factor of 133 percent in this memorandum.

[2] This provision would extend eligibility to two significant groups: (i) individuals who would meet current Medicaid eligibility requirements, for example as disabled adults, but who have incomes in excess of the existing State thresholds but less than 133 percent of the FPL; and (ii) people who live in households with incomes below 133 percent of the FPL but who have no other qualifying factors that make them eligible for Medicaid under prior law, such as being under age 18, age 65 or older, disabled, pregnant, or parents of eligible children.

sponsored health insurance would enroll in Medicaid for supplemental coverage.) Another 16 million persons (most of whom are currently uninsured) would receive individual insurance coverage through the newly created Exchanges, with the majority of these qualifying for Federal premium and cost-sharing subsidies. Finally, we estimate that the number of individuals with employer-sponsored health insurance would decrease overall by about 1 million, reflecting both gains and losses in such coverage under the PPACA.

As described in more detail in a later section of this memorandum, we estimate that overall national health expenditures under the health reform act would increase by a total of $311 billion (0.9 percent) during calendar years 2010-2019, principally reflecting the net impact of (i) greater utilization of health care services by individuals becoming newly covered (or having more complete coverage), (ii) lower prices paid to health providers for the subset of those individuals who become covered by Medicaid, (but with net Medicaid costs from provisions other than the coverage expansion), and (iii) lower payments and payment updates for Medicare services. Although several provisions would help to reduce health care cost growth, their impact would be more than offset through 2019 by the higher health expenditures resulting from the coverage expansions.

The actual future impacts of the PPACA on health expenditures, insured status, individual decisions, and employer behavior are very uncertain. The legislation would result in numerous changes in the way that health care insurance is provided and paid for in the U.S., and the scope and magnitude of these changes are such that few precedents exist for use in estimation. Consequently, the estimates presented here are subject to a substantially greater degree of uncertainty than is usually the case with more routine health care legislation.

The balance of this memorandum discusses these financial and coverage estimates—and their limitations in greater detail.

Effects of Coverage Provisions on Federal Expenditures and Health Insurance Coverage

Federal Expenditure Impacts

The estimated Federal costs of the coverage provisions in the PPACA are provided in table 1, attached, for fiscal years 2010 through 2019. We estimate that Federal expenditures would increase by a net total of $251 billion during this period as a result of the selected PPACA provisions—a combination of $828 billion in net costs associated with coverage provisions, $575 billion in net savings for the Medicare provisions, a net cost of $28 billion for the Medicaid/CHIP provisions (excluding the expansion of Medicaid eligibility and the additional CHIP funding), $2 billion in savings from provisions intended to help reduce the rate of growth in health spending, $38 billion in net savings from the CLASS program, and $10 billion in costs for the immediate insurance reforms. These latter five impact categories are discussed in subsequent sections of this memorandum.

Of the estimated $828 billion net increase in Federal expenditures related to the coverage provisions of the PPACA, about one-half ($410 billion) can be attributed to expanding Medicaid coverage for all adults who live in households with incomes below 133 percent of the FPL. This cost reflects the fact that newly eligible persons would be covered with a Federal Medical Assistance Percentage (FMAP) of over 99 percent for the first 3 years, declining to 93 percent by the sixth year; that is, the Federal government would bear a significantly greater proportion of

the cost of the newly eligible enrollees than is the case for current Medicaid beneficiaries.[3] Also included in this cost is the additional funding for the CHIP program for 2014 and 2015, which would increase such expenditures by an estimated $29 billion. The remaining costs of the coverage provisions arise from the refundable tax credits and reduced cost-sharing requirements for low-to-middle-income enrollees purchasing health insurance through the Exchanges ($507 billion) and credits for small employers who choose to offer insurance coverage ($31 billion). The increases in Federal expenditures would be partially offset by the penalties paid by affected individuals who choose to remain uninsured and employers who opt not to offer coverage; such penalties total $120 billion through fiscal year 2019, reflecting the relatively low per-person penalty amounts specified in the legislation.[4]

The refundable premium tax credits in section 1401 of the PPACA (as amended by section 1001 of the Reconciliation Act) would limit the premiums paid by individuals with incomes up to 400 percent of the FPL to a range of 2.0 to 9.5 percent of their income and would cost an estimated $451 billion through 2019. An estimated 25 million Exchange enrollees (79 percent) would receive these Federal premium subsidies. The cost-sharing credits would reimburse individuals and families with incomes up to 400 percent of the FPL for a portion of the amounts they pay out-of-pocket for health services, as specified in section 1402, as amended. These credits are estimated to cost $55 billion through 2019.

The PPACA establishes the Exchange premium subsidies during 2014-2018 in such a way that the reduced premiums payable by those with incomes below 400 percent of FPL would maintain the same share of total premiums over time. As a result, the Federal premium subsidies for a qualifying individual would grow at the same pace as per capita health care costs during this period. Because the cost-sharing assistance is based on a percentage of health care costs incurred by qualifying individuals and families, average Federal expenditures for this assistance would also increase at the same rate as per capita health care costs. After 2018, if the Federal cost of the premium and cost-sharing subsidies exceeded 0.504 percent of GDP, then the share of Exchange health insurance premiums paid by enrollees below 400 percent of the FPL would increase such that the Federal cost would stay at approximately 0.504 percent of GDP. We estimate that the subsidy costs in 2018 would represent about 0.518 percent of GDP, with the result that the enrollee share of the total premium would generally increase in 2019 and later.

As noted previously, the Federal costs for the coverage expansion provisions are somewhat offset by the individual and employer penalties stipulated by the PPACA. We estimate that individual penalties would provide $33 billion in revenue to the Federal government in fiscal years 2014-2019, taking into account the time lag associated with collecting the penalty amounts through the Federal income tax system. (A discussion of the estimated number of individuals who would choose to remain uninsured is provided below.) Additionally, for firms that do not

[3] For the newly eligible enrollees, the FMAP for fiscal year 2020 and later will be 90 percent, compared to an average of 57 percent for the previously eligible enrollee population. In addition, the estimated cost includes new Medicaid enrollments by previously eligible individuals as a result of the publicity, enrollment assistance through the Exchanges, and reduced stigma associated with Federal assistance for health care. Also included here are the Medicaid costs for the provision to extend Medicaid coverage to individuals up to age 26 who were previously in foster care.

[4] Employer penalties would be $2,000 per employee in 2014, generally, which is substantially less than the cost of providing health insurance coverage. The relationship between penalties and premiums is much more complicated for individuals than for employers; still, for many individuals the applicable penalty would be considerably smaller than the cost of coverage.

offer health insurance and are subject to the "play or pay" penalties, we estimate that the penalties would total $87 billion in 2014-2019.

The penalty amounts for noncovered individuals will be indexed over time by the CPI (or, in certain instances, by growth in income) and would normally increase more slowly than health care costs. As a result, penalty revenues for nonparticipating individuals are estimated to grow more slowly than the Federal expenditures for the premium assistance credits. Penalties for employers who do not offer health insurance will be indexed by premium levels and will thus keep pace with health care cost growth.

The health reform act specifies maximum out-of-pocket limits in 2014 equal to the corresponding maximums as defined in the Internal Revenue Code for high-deductible health plans. We estimate that these limits would be $6,645 for an individual and $13,290 for a family with qualified creditable coverage (including employer-sponsored health insurance). For future years, the limits are indexed to the growth in the average health insurance premium in the U.S. Under this approach, the proportion of health care costs above the out-of-pocket maximum would be relatively stable over time. For the basic "bronze" benefit plan for individuals, with an actuarial value of 60 percent, we estimate that the cost-sharing percentage applicable before the out-of-pocket maximum is reached would average about 76 percent in 2014 and later. The corresponding cost-sharing rate for family coverage is 64 percent. For the "silver" benefit package, the individual and family cost-sharing rates below the out-of-pocket maximums would average about 47 percent and 40 percent, respectively. For the more comprehensive "gold" and "platinum" benefit packages authorized through the Exchanges, these initial cost-sharing levels would be significantly lower.

Health Insurance Coverage Impacts

The estimated effects of the PPACA on health insurance coverage are provided in table 2, attached. As summarized earlier, we believe that these effects will be quite significant. By calendar year 2019, the individual mandate, Medicaid expansion, and other provisions are estimated to reduce the number of uninsured from 57 million under prior law to 23 million after the PPACA. The percentage of the U.S. population with health insurance coverage is estimated to increase from 83 percent under the prior-law baseline to 93 percent after the changes have become fully effective.

Of the additional 34 million people who are estimated to be insured in 2019 as a result of the PPACA, a little more than one-half (18 million) would receive Medicaid coverage due to the expansion of eligibility to adults under 133 percent of the FPL. (Included in the total are an estimated 50,000 individuals who would gain Medicaid coverage as former children in foster care programs and who could be covered up to age 26 under the new law.) We anticipate that the intended enrollment facilitation under the PPACA– i.e., that the Health Benefits Exchanges help people determine which insurance plans are available and identify whether individuals qualify for Medicaid coverage, premium subsidies, etc.—would result in a high percentage of eligible persons becoming enrolled in Medicaid. We further believe that the great majority of such persons (15 million) would become covered in the first year, 2014, with the rest covered by 2016. About 2 million people who currently have employer-sponsored health insurance are estimated to enroll in Medicaid as a supplement to their existing coverage.

We estimate that 16 million people would receive health coverage in 2019 through the newly created Exchanges under the PPACA. (Another 15 million, who currently have individual health insurance policies, are also expected to switch to Exchange plans.) We modeled the choice to purchase coverage from the Exchanges as a function of individuals' and families' expected health expenditures relative to the cost of coverage if they were insured (taking into account applicable premium subsidies). We also considered the required penalty associated with the individual mandate if they chose to remain uninsured, along with other factors.[5] Our model indicated that roughly 63 percent of those eligible for the Exchanges would choose to take such coverage, with the principal incentive being the level of premium assistance available. For many individuals, the penalty amounts for not having insurance coverage were not sufficiently large to have a sizable impact on the coverage decision. Also, in this regard, individuals or families would not be subject to a penalty for failing to enroll in an Exchange plan if the "bronze" premium level (reduced by the premium tax credit, if applicable) would exceed 8 percent of income. We estimate that this provision would exempt individuals and families with incomes between about 400 percent and 542 percent of the FPL, representing about 16 percent of the non-aged population.

The new legislation would require the Office of Personnel Management to arrange for at least two private, multi-State health plans to be offered through each health insurance Exchange. The multi-State plans would generally meet the same benefit, cost-sharing, network, and other requirements applicable to private Exchange plans and would negotiate payment rates with providers. (A State could enact a requirement for additional benefits in the multi-State plans, beyond the essential benefits specified for a qualified plan, but would have to make payments on behalf of eligible individuals to defray the cost of the additional benefits.) We estimate that the multi-State plans would have costs that were very similar to those for other Exchange plans.

Employer-sponsored health insurance has traditionally been the largest source of coverage in the U.S., and we anticipate that it would continue to be so under the PPACA. By 2019, an estimated 13 million workers and family members would become newly covered as a result of additional employers offering health coverage, a greater proportion of workers enrolling in employer plans, and an extension of dependent coverage up to age 26. However, a number of workers who currently have employer coverage would likely become enrolled in the expanded Medicaid program or receive subsidized coverage through the Exchanges. For example, some smaller employers would be inclined to terminate their existing coverage, and companies with low average salaries might find it to their—and their employees'—advantage to end their plans, thereby allowing their workers to qualify for heavily subsidized coverage through the Exchanges. Somewhat similarly, many part-time workers could obtain coverage more inexpensively through the Exchanges or by enrolling in the expanded Medicaid program. Finally, as mentioned previously, the per-worker penalties assessed on nonparticipating employers are relatively low compared to prevailing health insurance costs. As a result, the penalties would not be a substantial deterrent to dropping or forgoing coverage. We estimate that such actions would collectively reduce the number of people with employer-sponsored health coverage by about 14 million, or slightly more than the number newly covered through

[5] Such other factors include age, gender of head of household, race, children, marital status, health status, and employment status (for both the head of household and the spouse), as well as adjustments to reflect the availability of health insurance on a guaranteed-issue basis and at community-rated, group insurance premium rates. Finally, we also considered the general desire to comply with the intent of the law, even in the significant number of cases in which the penalty amount would be small or would not apply.

existing and new employer plans under the PPACA. As indicated in table 2, the total number of persons with employer coverage in 2019 is estimated to be 1 million lower under the reform legislation than under the prior law.

For the estimated 23 million people who would remain uninsured in 2019, roughly 5 million are undocumented aliens who would be ineligible for Medicaid or the Exchange coverage subsidies under the health reform legislation. The balance of 18 million would choose not to be insured and to pay the penalty (if applicable) associated with the individual mandate. For the most part, these would be individuals with relatively low health care expenses for whom the individual or family insurance premium would be significantly in excess of any penalty and their anticipated health benefit value. In other instances, as happens currently, some people would not enroll in their employer plans or take advantage of the Exchange opportunities even though it would be in their best financial interest to do so.

Impact on Medicare and Medicaid

Medicare

The estimated financial impacts of the Medicare provisions in the PPACA are provided in detail in table 3, attached, which is organized by section of the legislation.[6] Net Medicare savings are estimated to total $575 billion for fiscal years 2010-2019. Substantial savings are attributable to provisions that would, among other changes, reduce Part A and Part B payment levels and adjust future "market basket" payment updates for productivity improvements ($233 billion); eliminate the Medicare Improvement Fund ($27 billion); reduce disproportionate share hospital (DSH) payments ($50 billion); reduce Medicare Advantage payment benchmarks and permanently extend the authority to adjust for coding intensity ($145 billion); freeze the income thresholds for the Part B income-related premium for 9 years ($8 billion); implement an Independent Payment Advisory Board together with strict Medicare expenditure growth rate targets ($24 billion); and increase the HI payroll tax rate by 0.9 percentage point for individuals with incomes above $200,000 and families above $250,000 ($63 billion). Other provisions would generate relatively smaller amounts of savings, through such means as reporting physician quality measures, reducing payments in cases involving hospital-acquired infections, reducing readmissions, refining imaging payments, increasing Part D premiums for higher-income beneficiaries, and implementing evidence-based coverage of preventive services.

These savings are slightly offset by the costs of closing the Part D coverage gap ($12 billion); reducing the growth in the Part D out-of-pocket cost threshold ($1 billion); extending a number of special payment provisions scheduled to expire, such as the postponement of therapy caps ($5 billion); and by the costs for improving preventive health services and access to primary care ($6 billion).

[6] For ease of interpretation, we have incorporated the Medicare and Medicaid provisions of the managers' amendments, as specified in Title X of the PPACA, into the corresponding provisions of Titles II through VII and Title IX. For example, the savings shown for section 3403 (Independent Payment Advisory Board) represent the impact of this provision from the original bill as amended by Senate managers' amendment section 10320. Similarly, any further amendments introduced by the Reconciliation Act and managers' amendments to the Reconciliation Act have also been included with the corresponding title of the PPACA. For example, the costs under section 1101 of the Reconciliation Act, to close the Part D coverage gap or "donut hole," are included with the Part D provisions of PPACA, as are the costs of slowing the growth in the enrollee out-of-pocket cost threshold, as added by the managers' amendments to the Reconciliation Act.

The Reconciliation Act amendments introduced a new 3.8-percent "unearned income Medicare contribution" on income from interest, dividends, annuities, and other non-earnings sources for individual taxpayers with incomes above $200,000 and couples filing joint returns with incomes above $250,000. Despite the title of this tax, this provision is unrelated to Medicare; in particular, the revenues generated by the tax on unearned income are not allocated to the Medicare trust funds (and thus are not shown in table 3).

Conversely, the revenues from fees on manufacturers and importers of brand-name prescription drugs under section 9008 of the PPACA are earmarked for the Part B account in the Medicare Supplementary Medical Insurance trust fund. From the standpoint of the Federal Budget, these amounts are new receipts and serve to reduce the Budget deficit. From a trust fund perspective, however, the situation is more complicated. No changes were made in the existing statutory provisions for Part B beneficiary premiums and general revenue matching amounts, which by law are set each year at a level adequate to finance Part B expenditures. With no change to the existing financing, the additional revenues under section 9008 would result in an excessive level of financing for Part B and an unnecessary accumulation of account assets. It would be reasonable to establish a negative "premium margin" to maintain Part B assets at an appropriate contingency level, which would reduce beneficiary premium rates and matching general revenues by an amount equal to the new revenues from prescription drug fees. The estimated savings amounts shown in table 3 for section 9008 represent the net Budget impact (additional fee receipts less the reduction in beneficiary premiums). In practice, there would be no net impact on the operations of the Part B trust fund account.

Based on the estimated savings for Part A of Medicare, the assets of the Hospital Insurance trust fund would be exhausted in 2029 compared to 2017 under the prior law—an extension of 12 years. The combination of lower Part A costs and higher tax revenues results in a lower Federal deficit based on budget accounting rules. However, trust fund accounting considers the same lower expenditures and additional revenues as extending the exhaustion date of the HI trust fund. In practice, the improved HI financing cannot be simultaneously used to finance other Federal outlays (such as the coverage expansions) and to extend the trust fund, despite the appearance of this result from the respective accounting conventions.

It is important to note that the estimated savings shown in this memorandum for one category of Medicare provisions may be unrealistic. The PPACA introduces permanent annual productivity adjustments to price updates for most providers (such as hospitals, skilled nursing facilities, and home health agencies), using a 10-year moving average of economy-wide private, non-farm productivity gains. While such payment update reductions will create a strong incentive for providers to maximize efficiency, it is doubtful that many will be able to improve their own productivity to the degree achieved by the economy at large.[7] Over time, a sustained reduction in payment updates, based on productivity expectations that are difficult to attain, would cause Medicare payment rates to grow more slowly than, and in a way that was unrelated to, the

[7] The provision of most health services tends to be very labor-intensive. Economy-wide productivity gains reflect relatively modest improvements in the service sector together with much larger improvements in manufacturing. Except in the case of physician services, we are not aware of any empirical evidence demonstrating the medical community's ability to achieve productivity improvements equal to those of the overall economy. The Office of the Actuary's most recent analysis of hospital productivity highlights the difficulties in measurement but suggests that such productivity has been small or negligible during 1981 to 2005.
(See http://www.cms.hhs.gov/HealthCareFinancingReview/downloads/07-08Winterpg49.pdf.)

providers' costs of furnishing services to beneficiaries. Thus, providers for whom Medicare constitutes a substantive portion of their business could find it difficult to remain profitable and, absent legislative intervention, might end their participation in the program (possibly jeopardizing access to care for beneficiaries). Simulations by the Office of the Actuary suggest that roughly 15 percent of Part A providers would become unprofitable within the 10-year projection period as a result of the productivity adjustments.[8] Although this policy could be monitored over time to avoid such an outcome, changes would likely result in smaller actual savings than shown here for these provisions.

A related concern is posed by the requirements that will be placed on the Independent Payment Advisory Board. The Board will be charged with recommending changes to certain Medicare payment categories in an effort to prevent per-beneficiary Medicare costs from increasing faster than the average of the CPI and the CPI-medical for "implementation years" 2015 through 2019.[9] The Secretary of HHS is required to implement the Board's recommendations unless the statutory process is overridden by new legislation.

Average Medicare costs per beneficiary usually increase over time as a function of (i) medical-specific price growth, (ii) more utilization of services by beneficiaries, and (iii) greater "intensity" or average complexity of these services. In general, limiting cost growth to a level below medical price inflation alone would represent an exceedingly difficult challenge. Actual Medicare cost growth per beneficiary was below the target level in only 4 of the last 25 years, with 3 of those years immediately following the Balanced Budget Act of 1997; the impact of the BBA prompted Congress to pass legislation in 1999 and 2000 moderating many of the BBA provisions. As an additional comparison, during the last 25 years the average increase in the target growth rate has been 0.33 percent per year below the average increase in nominal GDP per capita which is approximately the target level for the physician sustainable growth rate (SGR) payment system. Congress has overridden the SGR-based payment reductions for each of the last 7 years (and, to date, for the first 5 months of 2010).

The Board's efforts would be further complicated by provisions that prohibit increases in cost-sharing requirements and that exempt certain categories of Medicare expenditures from consideration. We have estimated the savings for section 3403 under the assumption that the provision will be implemented as specified; in particular, we have not assumed that Congress would pass subsequent legislation to prevent implementation of the Board's recommendations. Although the savings from the other Medicare provisions in the PPACA are quite substantial, they would not be sufficient to meet the growth rate targets specified in conjunction with the Advisory Board. We estimate that meeting the growth rate targets in 2015-2019 would require changes that would reduce Medicare growth rates by another 0.3 percent per year, on average, in addition to the impacts of the productivity adjustments, MA and DSH reductions, and other provisions in the PPACA.

---

[8] The simulations were based on actual fiscal year 2007 Medicare and total facility margin distributions for hospitals, skilled nursing facilities, and home health agencies. Provider revenues and expenditures were projected using representative growth rates and the Office of the Actuary's best estimates of achievable productivity gains for each provider type, and holding all other factors constant. A sensitivity analysis suggested that the conclusions drawn from the simulations would not change significantly under different provider behavior assumptions.

[9] Maximum growth rate reductions of 0.5, 1.0, and 1.25 percentage points would apply to 2015, 2016, and 2017, respectively, and the maximum would be 1.5 percentage points thereafter. After implementation year 2019, the target growth amount would be based on the increase in per capita GDP plus 1 percentage point.

After 2019, further Advisory Board recommendations for growth rate reductions would generally not be required. The other Medicare savings provisions, if permitted to continue, would normally reduce expenditure growth rates to slightly below the post-2019 target level based on per capita GDP growth plus 1 percent. Even if Medicare growth rates exceeded the targets, recommendations might not be required if the projected Medicare growth rate were less than that for overall national health expenditures on a per capita basis—as would tend to be the case, given the continuing Medicare savings. (This exemption from the requirement to make recommendations could not be applied in 2 successive years.) Although the Advisory Board process would have no impact after 2019 based on the specific assumptions underlying these estimates, it would still serve as a brake during any periods of unusually rapid spending growth.

Under the prior law, Medicare Advantage payment benchmarks were generally in the range of 100 to 140 percent of fee-for-service costs. Section 1102 of reconciliation amendments sets the 2011 MA benchmarks equal to the benchmarks for 2010 and specifies that, ultimately, the benchmarks will equal a percentage (95, 100, 107.5, or 115 percent) of the fee-for-service rate in each county. During a transition period, the benchmarks will be based on a blend of the prior ratebook approach and the ultimate percentages. The phase-in schedule for the new benchmarks will occur over 2 to 6 years, with the longer transitions for counties with the larger benchmark decreases under the new method.

The PPACA, as amended, also introduces MA bonuses and rebate levels that are tied to the plans' quality ratings. Beginning in 2012, benchmarks will be increased for plans that receive a 4-star or higher rating on a 5-star quality rating system. The bonuses will be 1.5 percent in 2012, 3.0 percent in 2013, and 5.0 percent in 2014 and later. An additional county bonus, which is equal to the plan bonus, will be provided on behalf of beneficiaries residing in specified counties. The percentage of the "benchmark minus bid" savings provided as a rebate, which historically has been 75 percent, will also be tied to a plan's quality rating. In 2014, when the provision is fully phased in, the rebate share will be 50 percent for plans with a quality rating of less than 3.5 stars; 65 percent for a quality rating of 3.5 to 4.49; and 70 percent for a quality rating of 4.5 or greater.

The new provisions will generally reduce MA rebates to plans and thereby result in less generous benefit packages.[10] We estimate that in 2017, when the MA provisions will be fully phased in, enrollment in MA plans will be lower by about 50 percent (from its projected level of 14.8 million under the prior law to 7.4 million under the new law).

Medicaid/CHIP

The estimated Federal financial effects of the Medicaid and CHIP provisions in the PPACA are shown in table 4, attached. As noted earlier, the costs associated with the expansion of Medicaid eligibility to individuals and families with incomes below 133 percent of the FPL and to children previously in foster care are included with the national coverage provisions shown in table 1. The additional funding for the CHIP program is also included in table 1 with the other coverage provisions.

[10] MA plans use rebate revenues to reduce Medicare coinsurance requirements, add extra benefits such as vision or dental care, and/or reduce enrollee premiums for Part B or Part D of Medicare. The new law also requires adjustments to offset the impact of excess "coding intensity" in determining plan risk scores. These adjustments would prevent increases in future payments to MA plans as a result of such coding.

The total net Federal cost of the other Medicaid and CHIP provisions is estimated to be $28 billion in fiscal years 2010-2019 and reflects numerous cost increases and decreases under the individual provisions. Those with significant Federal savings include various provisions increasing the level of Medicaid prescription drug rebates ($24 billion) and reductions in Medicaid DSH expenditures ($14 billion). Interactions between the different sections of the legislation, such as the lower Medicare Part B premiums under the PPACA, contribute an additional $9 billion in reduced Medicaid outlays.

The key provisions that would increase Federal Medicaid and CHIP costs are the Medicaid "Community First Choice Option" and other changes to encourage home and community-based services ($29 billion), higher Federal matching rates for States with existing childless-adult coverage expansions ($24 billion), a temporary increase in payments to primary care physicians ($11 billion), and increased payments to the territories ($7 billion). (The net impact of the Medicaid and CHIP provisions on State Medicaid costs is a reduction totaling $33 billion through fiscal year 2019. These savings result in part because certain of the provisions reallocate costs from States to the Federal government.)

Impact of Provisions on the Rate of Growth in Health Care Costs

The PPACA includes a number of provisions that are intended, in part, to help control health care costs and to change the overall trend in health spending growth. Many of these are specific to the Medicare program, and their estimated financial effects are shown in table 3. While some of the Medicare provisions would have a largely one-time impact on the *level* of expenditures (for example, the reduction in MA benchmarks), others would have an effect on expenditure *growth rates*. Examples of the latter include the productivity adjustments to Medicare payment updates for most categories of providers, which would reduce overall Medicare cost growth by roughly 0.6 to 0.7 percent per year, and the Independent Payment Advisory Board process, which would further reduce Medicare growth rates during 2015-2019 by about 0.3 percent per year. As discussed previously, however, the growth rate reductions from productivity adjustments are unlikely to be sustainable on a permanent annual basis, and meeting the CPI-based target growth rates prior to 2020 will be very challenging as well.

The Independent Payment Advisory Board will also be required to periodically submit recommendations to Congress and the President regarding methods of slowing the growth of non-Federal health care programs. In many cases, Federal or State legislation would need to be enacted to implement these recommendations. In other cases, they could be adopted voluntarily by private health insurance plans or by health providers or introduced administratively by government entities. Because the nature of these broader recommendations is not known and there is no mandate to adopt them, we have not estimated an explicit impact on health care spending growth.

Another provision that would tend to moderate health care cost growth rates is the excise tax on high-cost employer-sponsored health insurance coverage (section 9001), which is described in more detail in the section of this memorandum on national health expenditures. In reaction to the tax, which would take effect in 2018, many employers would reduce the scope of their health benefits. The resulting reductions in covered services and/or increases in employee cost-sharing requirements would induce workers to use fewer services. Because plan benefit values will generally increase faster than the threshold amounts for defining high-cost plans (which, after

2019, are indexed by the CPI), additional plans would become subject to the excise tax over time, prompting many of those employers to scale back coverage. This continuing cycle would have a moderate impact on the overall growth of expenditures for employer-sponsored insurance. It should be noted, however, that an estimated 12 percent of insured workers in 2019 would be in employer plans with benefit values in excess of the thresholds (before changes to reduce benefits) and that this percentage would increase rapidly thereafter. The effect of the excise tax on reducing health care cost growth would depend on its ongoing application to an expanding share of employer plans and on an increasing scope of benefit reductions for affected plans. Since this provision is characterized as affecting high-cost employer plans, its broader and deeper impact could become an issue.

Certain other provisions of the PPACA are also intended to help control health care costs more generally, through promotion of comparative effectiveness research, greater use of prevention and wellness measures, administrative simplification, and augmented fraud and abuse enforcement. For fiscal years 2010 through 2019, we estimate a relatively small reduction in non-Medicare Federal health care expenditures of $2 billion for these provisions, all of which is associated with comparative effectiveness research.

Comparative Effectiveness Research

We reviewed literature and consulted experts to determine the potential cost savings that could be derived from comparative effectiveness research (CER). We found that the magnitude of potential savings varies widely depending upon the scope and influence of comparative effectiveness efforts. Small savings could be achieved through the wide availability of non-binding research, while substantial savings could be generated by a comparative effectiveness board with authority over payment and coverage policies.

Our interpretation of the CER provisions in the PPACA, which allow the Secretary of HHS to use evidence and findings from CER within defined limits in making coverage determinations under Medicare, is consistent with a low level of influence, translating into an estimated total reduction in national health expenditures of $8 billion for calendar years 2010 through 2019, and Federal savings of about $4 billion for fiscal years 2010 through 2019 (including Medicare). We anticipate that such savings would develop gradually, as changes in provider practice and culture evolved over time. Expert input on this subject suggests that the full impact of comparative effectiveness research, together with dissemination and application of its results, would take many years to develop.

Other Provisions

We show a negligible financial impact over the next 10 years for the other provisions intended to help control future health care cost growth. There is no consensus in the available literature or among experts that prevention and wellness efforts result in lower costs. Several prominent studies conclude that such provisions– while improving the quality of individuals' lives in important ways– generally increase costs overall. For example, while it is possible that savings can be achieved for many people by diagnosing diseases in early stages and promoting lifestyle

and behavioral changes that reduce the risk for serious and costly illnesses, additional costs are incurred as a result of increased screenings, preventive care, and extended years of life.[11]

Regarding the general fraud and abuse and administrative simplification provisions (that is, excluding the Medicare and Medicaid provisions), we find that the language is not sufficiently specific to provide estimates.

CLASS Program

Title VIII of the health reform act establishes a new, voluntary, Federal insurance program providing a cash benefit if a participant is unable to perform at least two or three activities of daily living or has substantial cognitive impairment. The program will be financed by participant premiums, with no Federal subsidy. Participants will have to meet certain modest work requirements during a 5-year vesting period before becoming eligible for benefits. Benefits are intended to be used to help purchase community living assistance services and supports (CLASS) that would help qualifying beneficiaries maintain their personal and financial independence and continue living in the community. Benefits can also be used to help cover the cost of institutional long-term care.

As shown in the table on page 2, we estimate a net Federal savings for the CLASS program of $38 billion during the first 9 years of operations—the first 5 of which are prior to the commencement of benefit payments. After 2015, as benefits are paid, the net savings from this program will decline; in 2025 and later, projected benefits exceed premium revenues, resulting in a net Federal cost in the longer term.[12]

We estimate that roughly 2.8 million persons will participate in the program by the third year. This level represents about 2 percent of potential participants, compared to a participation rate of 4 percent for private long-term care insurance offered through employers. Factors affecting participation in CLASS include the program's voluntary nature, the lack of a Federal subsidy, a minimal premium for students and individuals with incomes under 100 percent of the FPL (initially $5 per month), a relatively high premium for all other participants as a result of adverse selection and the effect of subsidizing participants paying the $5 premium, a new and unfamiliar benefit, and the availability of lower-priced private long-term care insurance for many.

Compounding this situation will be the probable participation of a significant number of individuals who already meet the functional limitation requirements to qualify for benefits. In the sixth year of the program (2016), these participants would begin to receive benefits, along with others who had developed such limitations in the interim. We estimate that an initial

[11] Title IV in the PPACA creates a Prevention and Public Health Fund and authorizes the appropriation of $15 billion for these purposes. We consider these expenditures to be primarily administrative in nature and thus have not included them as program costs in this memorandum.

[12] The CLASS program is intended to be financed on a long-range, 75-year basis through participant premiums that would fully fund benefits and administrative expenses. If this goal can be achieved, despite anticipated serious adverse selection problems (described subsequently), then annual expenditures would be met through a combination of premium income and interest earnings on the assets of the CLASS trust fund. The Federal Budget impact would be the net difference between premium receipts and program outlays. Thus, the trust fund would be adequately financed in this scenario, but the Federal Budget would have a net savings each year prior to 2025 and a net cost each year thereafter.

average premium level of about $240 per month would be required to adequately fund CLASS program costs for this level of enrollment, adverse selection, and premium inadequacy for students and low-income participants. (Except for those paying the $5 premium, individuals enrolling in a given year will pay a constant premium amount throughout their participation, unless trust fund deficits necessitate a premium increase. Premiums will vary by age at enrollment and by year of enrollment.)

In general, voluntary, unsubsidized, and non-underwritten insurance programs such as CLASS face a significant risk of failure as a result of adverse selection by participants. Individuals with health problems or who anticipate a greater risk of functional limitation would be more likely to participate than those in better-than-average health. Setting the premium at a rate sufficient to cover the costs for such a group further discourages persons in better health from participating, thereby leading to additional premium increases. This effect has been termed the "classic assessment spiral" or "insurance death spiral." The problem of adverse selection is intensified by requiring participants to subsidize the $5 premiums for students and low-income enrollees. Although Title VIII includes modest work requirements in lieu of underwriting and specifies that the program is to be "actuarially sound" and based on "an actuarial analysis of the 75-year costs of the program that ensures solvency throughout such 75-year period," there is a very serious risk that the problem of adverse selection will make the CLASS program unsustainable.[13]

Immediate Insurance Reforms

A number of provisions in the PPACA have an immediate effect on insurance coverage. Most of these provisions, however, do not have a direct impact on Federal expenditures. (A discussion of their impact on national health expenditures is included in the following section of this memorandum.) Section 1101 of the PPACA authorizes the expenditure of up to $5 billion in support of a temporary national insurance pool for high-risk individuals without other health insurance. Section 1102 requires the Secretary of HHS to establish a Federal reinsurance program in 2010-2013 for early retirees and their families in employer-sponsored health plans. Participation by employers is optional, and the law authorizes up to $5 billion in Federal financing for the reinsurance costs. No other financing is provided, and reinsurance claims would be paid only as long as the authorized amount lasts. We estimate that the full amount of the authorizations for sections 1101 and 1102 would be expended during the first 1 to 3 calendar years of operation.

National Health Expenditure Impacts

The estimated effects of the PPACA on overall national health expenditures (NHE) are shown in table 5. In aggregate, we estimate that for calendar years 2010 through 2019, NHE would increase by $311 billion, or 0.9 percent, over the updated baseline projection that was released on June 29, 2009.[14] Year by year, the relative increases are largest in 2016, when the coverage expansions would be fully phased in (2.0 percent), and gradually decline thereafter to 1.0 percent

[13] An analysis of the potential adverse selection problems for the CLASS program was performed by a nonpartisan, joint workgroup of the American Academy of Actuaries and the Society of Actuaries. Their report was issued on July 22, 2009 and is available at http://www.actuary.org/pdf/health/class_july09.pdf .

[14] R. Foster and S. Heffler, "Updated and Extended National Health Expenditure Projections, 2010-2019." Memorandum dated June 29, 2009. Available online at http://www.cms.hhs.gov/NationalHealthExpendData/Downloads/NHE_Extended_Projections.pdf.

in 2019, as the effects of the Medicare market basket reductions compound and as the excise tax on high-cost employer health plans becomes effective. The NHE share of GDP is projected to be 21.0 percent in 2019, compared to 20.8 percent under prior law.

The increase in total NHE is estimated to occur primarily as a net result of the substantial expansions in coverage under the PPACA, together with the expenditure reductions for Medicare. Numerous studies have demonstrated that individuals and families with health insurance use more health services than otherwise-similar persons without insurance. Under the health reform legislation, as noted above, an estimated 34 million currently uninsured people would gain comprehensive coverage through the health insurance Exchanges, their employers, or Medicaid. The availability of coverage would typically result in a fairly substantial increase in the utilization of health care services, with a corresponding impact on total health expenditures. These higher costs would be partially offset by the sizable discounts imposed on providers by State Medicaid payment rules and by the significant discounts negotiated by private health insurance plans. We estimate that the net effect of the utilization increases and price reductions arising from the coverage provisions of the PPACA would increase NHE in 2019 by about 3.4 percent.

The PPACA will also affect aggregate NHE through the Medicare savings provisions. We estimate that these impacts would reduce NHE by roughly 2.4 percent in 2019, assuming that the productivity adjustments to Medicare payment updates and the impacts of the Independent Payment Advisory Board can be sustained through this period. The legislation would have only a slight impact on the utilization of health care services by Medicare beneficiaries (subject to the caveat mentioned previously regarding possible access issues under the provision to permanently reduce annual provider payment updates by economy-wide productivity gains). Medicaid outlays for health care would increase under some provisions and decrease under others; excluding the coverage expansion, the overall higher level of such costs would lower total U.S. health expenditures in 2019 by about 0.1 percent.

The immediate insurance reforms in Title I will affect national health expenditures as well, although by relatively small amounts. We estimate that the creation of a national high-risk insurance pool will result in roughly 375,000 people gaining coverage in 2010, increasing national health spending by $4 billion. By 2011 and 2012 the initial $5 billion in Federal funding for this program would be exhausted, resulting in substantial premium increases to sustain the program; we anticipate that such increases would limit further participation. An estimated 2.7 million retirees and dependents would be affected by the Federal reinsurance program for early retirees with employer-sponsored insurance. Although the reinsurance program would increase Federal costs by the allotted $5 billion, we estimate that the impact on total national health expenditures would be negligible.

Beginning in 2010, qualified child dependents below age 26 who are uninsured will be allowed to enroll under dependent coverage. An estimated 485,000 dependent children will gain insurance coverage through their parents' private group health plans, increasing national health spending by $0.9 billion. These impacts are expected to persist through 2013. Additionally, because this provision would not expire when the Medicaid expansion, individual mandate, and Exchanges start in 2014, we anticipate that these individuals would continue to remain covered as dependents even though they may be newly eligible for other coverage. Finally, we did not estimate NHE coverage or cost impacts for the other immediate reform provisions, such as prohibiting limitations on pre-existing conditions or elimination of lifetime aggregate benefit

limits. We believe that each of these provisions would have only a relatively minor upward impact on national health spending.

Section 9001 of the PPACA places an excise tax on employer-sponsored health insurance coverage with a benefit value above specified levels (generally $10,200 for individuals and $27,500 for families in 2018, adjusted in 2019 by growth in the CPI plus 1 percentage point and by growth in the CPI thereafter).[15] The tax is 40 percent of the excess benefit value above these thresholds. We estimate that, in aggregate, affected employers will reduce their benefit packages in such a way as to eliminate about three-quarters of the excess benefit value. The resulting higher cost-sharing requirements for employees would have an initial impact on the overall level of health expenditures, reducing total NHE by an estimated 0.1 percent in 2019. Moreover, because health care costs will generally increase faster than the CPI, we anticipate additional, incremental benefit coverage reductions in future years to prevent an increase in the share of employer coverage subject to the excise tax. These further adjustments would contribute to a small reduction in the growth in total health care costs (but an increase in out-of-pocket costs) for affected employees in 2019 and later.[16] As mentioned earlier, the proportion of workers experiencing reductions in their employer-sponsored health coverage as a result of the excise tax is estimated to increase rapidly after 2019.

The health reform legislation, as enacted, imposes collective annual fees on manufacturers and importers of brand-name prescription drugs and on health insurance plans. In addition, the PPACA establishes an excise tax on non-personal-use retail sales by manufacturers and importers of medical devices. For manufacturers and importers of brand-name prescription drugs, the fee is $2.5 billion in 2011, increasing to a maximum of $4.1 billion by 2018, and then is set at $2.8 billion per year in 2019 and beyond.[17] For insurers, the annual fee is set at $8.0 billion starting in 2014 and rises to $14.3 billion by 2018; thereafter, the fee increases by the rate of premium growth. In each case, the total annual fee amount would be assessed on the specified industry as a whole; the share of the fee payable by any given firm in that industry would be determined based on sales (for manufacturers and importers of drugs) and on net premiums (in the case of insurers), with some limited exemptions. The excise tax on medical device sales is effective in 2011 and is set at 2.3 percent of first sales in each year. We anticipate that these fees and the excise tax would generally be passed through to health consumers in the form of higher drug and device prices and higher insurance premiums, with an associated increase in overall national health expenditures ranging from $2.1 billion in 2011 to $18.2 billion in 2018 and $17.8 billion in 2019.

Although, compared to prior law, the *level* of total national health expenditures is estimated to be higher through 2019 under the PPACA, two particular provisions of the legislation would help reduce NHE *growth rates* after 2016. Specifically, the productivity adjustments to most Medicare payment updates would reduce NHE growth by about 0.10 to 0.15 percent per year. In addition, the excise tax on high-cost employer health plans (with benefit thresholds indexed by the CPI plus 1 percent for 2019 and by the CPI thereafter) would exert a further decrease in NHE

[15] Higher thresholds apply in the case of qualified retirees and individuals in high-risk occupations. Additionally, a higher threshold applies for employers with above-average proportions of older and/or female workers.

[16] We have not included the excise taxes under this provision in the estimated financial effects of the PPACA shown in this memorandum. Similarly, the indirect impacts on Federal income taxes and social insurance payroll taxes are not shown.

[17] These fees are allocated to the Part B account of the Medicare Supplementary Medical Insurance trust fund.

growth rates of an estimated 0.05 percent in 2019 and slightly more than that for some years after. Although these growth rate differentials are not large, over time they would have a noticeable downward effect on the level of national health expenditures. Such an outcome, however, would depend critically on the sustainability of both provisions. As discussed previously, the Medicare productivity adjustments could become unsustainable even within the next 10 years, and over time the reductions in the scope of employer-sponsored health insurance could also become an issue. For these reasons, the estimated reductions in NHE growth rates after 2016 may not be fully achievable.

Underlying the overall moderate effects of the PPACA on NHE will be various changes by payer. Based on the net impact of (i) the substantial coverage expansions, (ii) the significant cost-sharing subsidies for low-to-middle-income persons, (iii) the maximum out-of-pocket limitations associated with the qualified health benefit, and (iv) the increases in workers' cost-sharing obligations in plans affected by the excise tax on high-cost employer-sponsored health insurance coverage, we estimate that overall out-of-pocket spending would be reduced significantly by the PPACA (a net total decline of $237 billion in calendar years 2010-2019).

Public spending would increase under the PPACA as a result of the expansion of the Medicaid program and additional CHIP funding but would be reduced by the net Medicare savings from the legislation. Private expenditures would decrease somewhat because of the net reduction in the number of persons with employer-sponsored health insurance and the reduced benefits for plans affected by the excise tax on high-cost employer coverage. The sizable growth in health insurance coverage through Exchange plans would also affect NHE amounts by payer. Prior to the PPACA, public expenditures (principally Medicare and Medicaid) were estimated to represent 52 percent of total NHE in 2019. Under the PPACA, the public share would be roughly 51 percent if health expenditures by Exchange plans are classified as private spending.[18]

Caveats and Limitations of Estimates

The Federal costs and savings, changes in health insurance coverage, and effects on total national health expenditures presented in this memorandum represent the Office of the Actuary's best estimates for the PPACA. Although we believe that these estimates are reasonable and fairly portray the likely future effects of this comprehensive package of health care reforms, they are

[18] The allocation of NHE *by payer* is based on the entity that is responsible for establishing the coverage and benefit provisions and that has the primary responsibility to ensure that payment is made for health care services. (Auxiliary analyses of NHE *by sponsor* are also prepared, based on the financing of health expenditures in the U.S.) Because all Exchange plans will be private plans, under the traditional NHE classification approach these expenditures would be considered private health insurance spending. However, the classification of health expenditures made by Exchange plans is complicated by three factors:

(i) The Exchanges will be government entities, with a role in setting minimum benefit standards, but they will not directly provide health insurance coverage. The same situation applies to the multi-State Exchange plans arranged by the Office of Personnel Management.

(ii) The Federal government, through the refundable tax credits and cost-sharing reductions, will subsidize a significant portion of Exchange plan premiums and cost-sharing liabilities.

(iii) The premium subsidies will vary between zero and 100 percent from one person to another, and the cost-sharing subsidies from zero to 80 percent on an insurance-value basis.

A more precise determination of the appropriate classification of the Exchange plan expenditures based on national health expenditure accounting principles will be conducted in the future.

subject to much greater uncertainty than normal. The following caveats should be noted, and the estimates should be interpreted cautiously in view of their limitations.

- These financial and coverage impacts are based on the provisions of the PPACA as enacted on March 23, 2010 and amended on March 30 by the Health Care and Education Reconciliation Act of 2010.

- Many of the provisions, particularly the coverage expansions, are unprecedented or have been implemented only on a smaller scale (for example, at the State level). Consequently, little historical experience is available with which to estimate the potential impacts.

- The behavioral responses to changes introduced by national health reform legislation are impossible to predict with certainty. In particular, the responses of individuals, employers, insurance companies, and Exchange administrators to the new coverage mandates, Exchange options, and insurance reforms could differ significantly from the assumptions underlying the estimates presented here.

- The nominal dollar amounts of costs and savings under national health reform are sensitive to the assumed trajectory of future health cost trends. Relative measures, such as the cost as a percentage of GDP, are less sensitive.

- Due to the very substantial challenges inherent in modeling national health reform legislation, our estimates will vary from those of other experts and agencies. Differences in results from one estimating entity to another may tend to cause confusion among policy makers. These differences, however, provide a useful reminder that all such estimates are uncertain and that actual future impacts could differ significantly from the estimates of any given organization. Indeed, the future costs and coverage effects could lie outside of the range of estimates provided by the various estimators.

- The existing number of uninsured persons in the U.S. is difficult to measure, and the number of uninsured persons who are undocumented aliens is considerably more uncertain. Medicaid coverage and Exchange premium subsidies under the PPACA are not available to undocumented aliens. As a result of these measurement difficulties, the actual costs under the PPACA and the reduction in the number of uninsured persons may be somewhat higher or lower than estimated in this memorandum.

- Certain Federal costs and savings were not included in our estimates if (i) a provision would have no, or only a minor, impact; (ii) the legislative language did not provide sufficient detail with which to estimate a provision's impact; or (iii) the estimates are outside of the scope of the Office of the Actuary's expertise and will be prepared by other agencies. In particular, we did not include any Federal savings pertaining to the excise tax on high-cost employer-sponsored health insurance coverage, the fees on insurance plans, the excise tax on devices, and other non-Medicare revenue provisions of the PPACA, as those estimates are provided by the Department of the Treasury. (In contrast, the impacts of these provisions on national health expenditures are reflected.) Similarly, Federal administrative expenses associated with the PPACA are not included here and will be estimated separately. The Congressional Budget Office and the Joint Committee on Taxation have estimated that the total amount of Medicare savings and additional excise tax and other revenues would somewhat more than offset the cost of the national coverage provisions, resulting in an overall small reduction in the Federal

deficit through 2019, and for the following 10 years as well, if all of the provisions continued to be fully implemented.

- In estimating the financial impacts of the PPACA, we assumed that the increased demand for health care services could be met without market disruptions. In practice, supply constraints might initially interfere with providing the services desired by the additional 34 million insured persons. Price reactions—that is, providers successfully negotiating higher fees in response to the greater demand—could result in higher total expenditures or in some of this demand being unsatisfied. Alternatively, providers might tend to accept more patients who have private insurance (with relatively attractive payment rates) and fewer Medicare or Medicaid patients, exacerbating existing access problems for Medicaid enrollees. Either outcome (or a combination of both) should be considered plausible and even probable initially.

  The latter possibility is especially likely in the case of the substantially higher volume of Medicaid services, for which provider payment rates are well below average. Therefore, it is reasonable to expect that a significant portion of the increased demand for Medicaid would be difficult to meet, particularly over the first few years.

  We have not attempted to model that impact or other plausible supply and price effects, such as supplier entry and exit or cost-shifting towards private payers. A specific estimate of these potential outcomes is impracticable at this time, given the uncertainty associated with both the magnitude of these effects and the interrelationships among these market dynamics. We may incorporate such factors in future estimates, should we determine that they can be estimated with a reasonable degree of confidence. For now, we believe that consideration should be given to the potential consequences of a significant increase in demand for health care meeting a relatively fixed supply of health care providers and services.

- As stated in the section on Medicare estimates, reductions in payment updates to health care providers, based on economy-wide productivity gains, are unlikely to be sustainable on a permanent annual basis. If these reductions were to prove unworkable within the 10-year period 2010-2019 (as appears probable for significant numbers of hospitals, skilled nursing facilities, and home health agencies), then the actual Medicare savings from these provisions would be less than shown in this memorandum. Similarly, the further reductions in Medicare growth rates mandated for 2015 through 2019 through the Independent Payment Advisory Board may be difficult to achieve in practice.

- In estimating the financial impact of the Medicaid eligibility expansion, we assumed that existing and new Medicaid enrollees would be appropriately classified for FMAP purposes.

- As discussed in the section on the CLASS program, we believe that there is a very serious risk that the program, as currently specified, will not be sustainable because of adverse selection.

Conclusions

The national health care reform provisions in the Patient Protection and Affordable Care Act, as amended, make far-reaching changes to the health sector, including mandated coverage for most people, required payments by most employers not offering insurance, expanded eligibility for Medicaid, Federal premium and cost-sharing subsidies for many individuals and families, a new system of health benefits Exchanges for facilitating coverage, and a new Federal insurance

program in support of long-term care. Additional provisions will reduce Medicare outlays, make other Medicaid modifications, provide more funding for the CHIP program, add certain benefit enhancements for these programs, and combat fraud and abuse. Federal revenues will be increased through an excise tax on high-cost insurance plans; fees or excise taxes on drugs, devices, and health plans; higher Hospital Insurance payroll taxes for high-income taxpayers; a new tax on investment revenues and other unearned income; and other provisions.

The Office of the Actuary at CMS has estimated the effects of the non-tax provisions of the PPACA on Federal outlays, overall national health expenditures, and health insurance coverage in the U.S. Our estimates are based on available data sources and what we believe are reasonable assumptions regarding individual, employer, and health plan responses to the legislation, together with analyses of the likely changes in the cost and use of health care services. Our primary estimates for the PPACA are as follows:

- The total Federal cost of the national insurance coverage provisions would be about $828 billion during fiscal years 2010 through 2019.

- By 2019, an additional 34 million U.S. citizens and other legal residents would have health insurance coverage meeting the essential-benefit requirements.

- Total net savings in 2010-2019 from Medicare provisions would offset about $575 billion of the Federal costs for the national coverage provisions. The Medicaid and CHIP provisions, excluding the expansion of Medicaid and increased CHIP funding, would raise costs by $28 billion. Additional Federal revenues would further offset the coverage costs; however, the Office of the Actuary does not have the expertise necessary to estimate all such impacts. The Congressional Budget Office and the Joint Committee on Taxation have estimated an overall reduction in the Federal Budget deficit through 2019 under the PPACA.

- The new Community Living Assistance Services and Supports (CLASS) insurance program would produce an estimated total net savings of $38 billion through fiscal year 2019. This effect, however, is due to the initial 5-year period during which no benefits would be paid. Over the longer term, expenditures would exceed premium receipts, and there is a very serious risk that the program would become unsustainable as a result of adverse selection by participants.

- Total national health expenditures in the U.S. during 2010-2019 would increase by about 0.9 percent. The additional demand for health services could be difficult to meet initially with existing health provider resources and could lead to price increases, cost-shifting, and/or changes in providers' willingness to treat patients with low-reimbursement health coverage.

- The mandated reductions in Medicare payment updates for providers, the actions of the Independent Payment Advisory Board, and the excise tax on high-cost employer-sponsored health insurance would have a downward impact on future health care cost growth rates. During 2010-2019, however, these effects would be outweighed by the increased costs associated with the expansions of health insurance coverage. Also, the longer-term viability of the Medicare update reductions is doubtful. Other provisions, such as comparative effectiveness research, are estimated to have a relatively small effect on expenditure growth rates.

We hope that the information presented here will be of value to policy makers and administrators as they endeavor to implement and monitor the health reform act.

Richard S. Foster, FSA, MAAA
Chief Actuary

Attachments: 5

Table 1 — Estimated Federal Costs (+) or Savings (-) under the Patient Protection and Affordable Care Act, as Enacted and Amended, in billions

	Fiscal Year										Total, FY
Provisions	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019
Total*	$9.2	-$0.7	-$12.6	-$22.3	$16.8	$57.9	$63.1	$54.2	$47.2	$38.5	$251.5
Coverage Provisions:	3.3	4.6	4.9	5.2	82.9	119.2	138.2	146.6	157.6	165.8	828.2
Medicaid Expansion and CHIP Funding	—	–		—	38.8	62.9	78.7	72.2	76.3	81.2	410.3
Credits:	3.3	4.6	4.9	5.2	49.6	67.6	77.9	99.1	110.3	115.5	537.9
Individual Exchange Subsidies:	—	—	—	—	43.9	61.4	76.3	99.1	110.3	115.5	506.5
Refundable Premium Tax Credits	—	—	—	—	38.4	54.2	68.3	88.6	98.7	103.0	451.1
Reduced Cost-Sharing Requirements	—	—	—	—	5.5	7.2	8.0	10.5	11.6	12.5	55.4
Small Employer Credits	3.3	4.6	4.9	5.2	5.7	6.2	1.6	0.0	0.0	0.0	31.4
Penalties:	—	—	—	—	-5.5	-11.3	-18.4	-24.7	-29.0	-30.9	-119.9
Individual Penalties	–	—	—	—	0.0	-2.4	-5.3	-7.6	-8.6	-9.2	-33.1
Employer Penalties			—	—	-5.5	-9.0	-13.0	-17.1	-20.4	-21.8	-86.8
Medicare	1.2	-4.7	-14.9	-26.3	-68.8	-60.3	-75.2	-92.1	-108.2	-125.7	-575.1
Medicaid/CHIP (Excluding Coverage Expansions)	-0.9	-0.9	0.8	4.5	8.6	5.1	4.6	3.4	1.3	1.7	28.3
Cost Trend Proposals:	—	—	–	—	0.0	-0.1	-0.2	-0.4	-0.6	-0.9	-2.3
Comparative Effectiveness Research†	—	—	—		0.0	-0.1	-0.2	-0.4	-0.6	-0.9	-2.3
Prevention and Wellness	—	—	—		0.0	0.0	0.0	0.0	0.0	0.0	0.0
Fraud and Abuse	—	—	—	—	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Administrative Simplification	—	—	—	—	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Additional Proposals:	5.6	0.4	-3.3	-5.6	-5.9	-6.0	-4.3	-3.4	-2.8	-2.4	-27.8
CLASS Program	–	-2.8	-4.5	-5.6	-5.9	-6.0	-4.3	-3.4	-2.8	-2.4	-37.8
Immediate Reforms	5.6	3.2	1.2	—	—	–	—	—	—	—	10.0

* Excludes Title IX revenue provisions except for sections 9008 (fees on manufacturers and importers of brand-name prescription drugs) and 9015 (additional HI payroll tax). Also excludes certain provisions with limited impacts and Federal administrative costs.

† Excludes the Medicare impact of CER, which is included in the Medicare savings total.

Source: Centers for Medicare & Medicaid Services, Office of the Actuary.

April 22, 2010

Table 2 — Estimated Effects of the Patient Protection and Affordable Care Act, as Enacted and Amended, on Enrollment by Insurance Coverage, in millions

	Calendar Year									
Prior Law Baseline	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Medicare	46.9	48.0	49.4	50.9	52.4	53.9	55.4	57.1	58.7	60.5
Medicaid/CHIP	59.2	60.5	61.6	62.0	60.6	60.3	61.1	61.9	62.7	63.5
Other Public	12.3	12.6	12.9	13.2	13.6	13.9	14.2	14.6	14.9	15.2
Employer-Sponsored Private Health Insurance	163.8	163.2	164.5	165.0	166.1	166.6	166.4	166.2	166.0	165.9
Other Private Health Insurance*	26.1	25.3	25.5	25.6	25.8	25.8	25.8	25.8	25.8	25.7
Uninsured	48.3	48.6	47.9	48.1	50.0	51.7	53.1	54.4	55.6	56.9
Insured Share of US Population†	84.4%	84.5%	84.8%	84.9%	84.4%	84.0%	83.8%	83.5%	83.3%	83.0%

	Calendar Year									
New Law PPACA	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Medicare	46.9	48.0	49.4	50.9	52.4	53.9	55.4	57.1	58.7	60.5
Medicaid/CHIP	59.2	60.5	61.6	62.0	83.6	84.6	84.1	82.1	82.9	83.9
Other Public	12.6	12.6	12.9	13.2	13.6	13.9	14.2	14.6	14.9	15.2
Employer-sponsored Private Health Insurance	164.3	163.7	164.9	165.5	168.1	169.0	166.6	164.7	163.7	164.5
Other Private Health Insurance*	26.1	25.3	25.5	25.6	12.6	12.2	11.5	10.9	10.4	10.0
Exchanges	—	—	—	—	16.9	18.6	24.8	29.8	31.4	31.6
Uninsured	47.5	48.1	47.4	47.6	23.8	22.2	21.0	22.0	22.8	23.1
Insured Share of US Population†	84.7%	84.6%	85.0%	85.0%	92.6%	93.2%	93.6%	93.3%	93.1%	93.1%

	Calendar Year									
Impact of PPACA	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Medicare	—	—	—	–	—	—	–	—	—	—
Medicaid/CHIP	—	—	—	—	23.0	24.3	23.1	20.2	20.2	20.4
Other Public	0.3	—	—	—	—	—	—	—	–	—
Employer-sponsored Private Health Insurance	0.5	0.5	0.5	0.5	2.0	2.5	0.2	-1.5	-2.4	-1.4
Other Private Health Insurance*		–	—	—	-13.2	-13.7	-14.3	-14.9	-15.3	-15.7
Exchanges				—	16.9	18.6	24.8	29.8	31.4	31.6
Uninsured	-0.9	-0.5	-0.5	-0.5	-26.2	-29.5	-32.1	-32.4	-32.9	-33.8
Insured Share of US Population†	0.3%	0.2%	0.2%	0.2%	8.2%	9.1%	9.8%	9.8%	9.9%	10.1%

* In the prior-law baseline, other private health insurance includes private Medicare supplemental coverage and individual coverage. In the new-law estimates, other private health insurance includes only those with Medicare supplemental coverage.

† Calculated as a proportion of total U.S. population, including unauthorized immigrants.

Source: Centers for Medicare & Medicaid Services, Office of the Actuary.

April 22, 2010

Table 3—Estimated Medicare Costs (+) or Savings (–) under the Patient Protection and Affordable Care Act, as Enacted and Amended

(Amounts in millions)

Sec.	Provision	Fiscal year										Total	
		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-14	2010-19
	TITLE III-IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE												
	SUBTITLE A-TRANSFORMING THE HEALTH CARE DELIVERY SYSTEM												
	PART I-LINKING PAYMENT TO QUALITY OUTCOMES IN THE MEDICARE PROGRAM												
3001	Hospital Value-Based Purchasing	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
3002	Physician Quality Reporting Initiative	0	0	0	210	120	-190	-390	-580	-560	-530	330	-1,920
3003	Expansion of Physician Feedback Program	0	0	0	0	0	0	0	0	0	0	0	0
3004	Quality Reporting for Long-Term Care Hospitals, Inpatient Rehabilitation Hospitals, and Hospice Programs	0	0	0	0	-30	-30	-30	-30	-20	-20	-30	-160
3005	Quality Reporting for PPS-exempt Cancer Hospitals	0	0	0	0	0	0	0	0	0	0	0	0
3006	Value-based Purchasing for SNF, IRHA, & ASC	0	0	0	0	0	0	0	0	0	0	0	0
3007	Value-based Payment Modifier under Physician Fee Schedule	0	0	0	0	0	0	0	0	0	0	0	0
3008	Payment Adjustment for Conditions Acquired in Hospitals	0	0	0	0	0	-520	-610	-660	-700	-750	0	-3,240
	PART II-NATIONAL STRATEGY TO IMPROVE HEALTH CARE QUALITY												
3011	National Strategy	0	0	0	0	0	0	0	0	0	0	0	0
3012	Interagency Working Group on Health Care Quality	0	0	0	0	0	0	0	0	0	0	0	0
3013	Quality Measure Development	0	0	0	0	0	0	0	0	0	0	0	0
3014	Quality and Efficiency Measurement	0	0	0	0	0	0	0	0	0	0	0	0
3015	Data Collection; Public Reporting	0	0	0	0	0	0	0	0	0	0	0	0
	PART III-ENCOURAGING DEVELOPMENT OF THE NEW PATIENT CARE MODELS												
3021	CMS Innovation Center	0	0	0	0	0	0	0	0	0	0	0	0
3022	Medicare Shared Savings Program	0	0	0	0	0	0	0	0	0	0	0	0
3023	National Pilot Program on Payment Bundling	0	0	0	0	0	0	0	0	0	0	0	0
3024	Independence at Home Demonstration Program	0	0	0	0	0	0	0	0	0	0	0	0
3025	Hospital Readmissions Reduction Program	0	0	0	-530	-630	-1,180	-1,320	-1,410	-1,510	-1,620	-1,160	-8,200
3026	Community-Based Care Transitions Program												
	Part A	0	100	100	100	100	100	0	0	0	0	400	500
	Part B	0	0	0	0	0	0	0	0	0	0	0	0
3027	Extension of Gainsharing Demonstration	0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE B-IMPROVING MEDICARE FOR PATIENTS AND PROVIDERS												
	PART I-ENSURING BENEFICIARY ACCESS TO PHYSICIAN CARE AND OTHER SERVICES												
3101	Increase in Physician Payment Update	0	0	0	0	0	0	0	0	0	0	0	0
3102	Extension of Floor on Medicare Work Geographic Adjustment	510	780	290	0	0	0	0	0	0	0	1,580	1,580
3103	Extension of Exceptions for Therapy Caps	520	1,160	500	10	10	20	20	20	20	20	2,200	2,300
3104	Extension of Treatment of Certain Physician Pathology Services	40	80	40	0	0	0	0	0	0	0	160	160
3105	Extension of Ambulance Add-ons	20	10	0	0	0	0	0	0	0	0	30	30
3106	Extension of Long-Term Care Hospital Provisions	30	440	530	140	10	0	0	0	0	0	1,150	1,150
3107	Extension of Physician Fee Schedule Mental Health Add-on	40	20	0	0	0	0	0	0	0	0	60	60
3108	Permitting Physician Assistants to Order Post-Hospital Extended Care Services	0	0	0	0	0	0	0	0	0	0	0	0
3109	Exemption of Certain Pharmacies from Accreditation Requirement	0	0	0	0	0	0	0	0	0	0	0	0
3110	Part B Special Enrollment for Disabled TRICARE	0	10	20	30	40	40	40	40	50	50	100	320

Table 3—Estimated Medicare Costs (+) or Savings (–) under the Patient Protection and Affordable Care Act, as Enacted and Amended

(Amounts in millions)

Sec.	Provision	Fiscal year										Total,	
		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-14	2010-19
3111	Bone Density Tests	20	40	20	0	0	0	0	0	0	0	80	80
3112	Revision to Medicare Improvement Fund												
	Part A	0	0	0	0	-15,350	0	0	0	0	0	-15,350	-15,350
	Part B	0	0	0	0	-11,890	0	0	0	0	0	-11,890	-11,890
3113	Treatment of Certain Complex Diagnostic Lab Tests	0	0	0	0	0	0	0	0	0	0	0	0
3114	Improved Access for Certified Midwife Services	0	0	0	0	0	0	0	0	0	0	0	0
	PART II-RURAL PROTECTIONS												
3121	Extend of Outpatient Hold Harmless Provision	50	20	0	0	0	0	0	0	0	0	70	70
3122	Extend Reasonable Cost Reimbursement for Laboratory Services in Small Rural Hospitals	0	0	0	0	0	0	0	0	0	0	0	0
3123	Extend Rural Community Hospital Demonstration Program	0	0	0	0	0	0	0	0	0	0	0	0
3124	Extend Medicare Dependent Hospital Program	0	0	100	10	0	0	0	0	0	0	110	110
3125	Improvements to Hospital Payments for Low-volume Hospitals	0	100	110	10	0	0	0	0	0	0	220	220
3126	Demonstration Project on Community Health Integration Models	0	0	0	0	0	0	0	0	0	0	0	0
3127	MEDPAC Study on Payments in Rural Areas	0	0	0	0	0	0	0	0	0	0	0	0
3128	Technical Correction to Critical Access Hospital Services	0	0	0	0	0	0	0	0	0	0	0	0
3129	Medicare Rural Hospital Flexibility Program	0	0	0	0	0	0	0	0	0	0	0	0
	PART III-IMPROVING PAYMENT ACCURACY												
3131	Payment Adjustment for Home Health Care												
	Part A	20	-220	-370	-410	-690	-1,140	-1,710	-2,340	-2,700	-2,900	-1,670	-12,460
	Part B	20	-260	-450	-510	-860	-1,410	-2,120	-2,900	-3,350	-3,600	-2,060	-15,440
3132	Hospice Reform	0	0	0	0	0	0	0	0	0	0	0	0
3133	Improvement to Medicare DSH Payments	0	0	0	0	-110	-7,100	-9,170	-10,610	-11,180	-11,760	-110	-49,930
3134	Misvalued Codes under Physician Fee Schedule	0	0	0	0	0	0	0	0	0	0	0	0
3135	Equipment Utilization Factor for Advanced Imaging Services	0	-110	-170	-200	-210	-230	-240	-260	-270	-290	-690	-1,980
3136	Revision of Payment for Power Wheelchairs	0	-40	-50	-50	-50	-60	-70	-70	-80	-80	-190	-550
3137	Hospital Wage Index Improvement	260	30	0	0	0	0	0	0	0	0	290	290
3138	Treatment of Certain Cancer Hospitals	0	0	0	0	0	0	0	0	0	0	0	0
3139	Payment for Biosimilar Biological Products												
	Part B	0	0	0	10	20	-350	-810	-960	-1,150	-1,360	-30	-4,600
	Part D	0	0	0	10	-20	-80	-130	-150	-180	-220	-10	-770
3140	Hospice Concurrent Care Demonstration	0	0	0	0	0	0	0	0	0	0	0	0
3141	Budget Neutrality in Calculation of Hospital Wage Index Floor	0	0	0	0	0	0	0	0	0	0	0	0
3142	Study on Urban Medicare-dependent Hospitals	0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE C-PROVISIONS RELATING TO PART C												
3201	Medicare Advantage Payment												
	Part A	0	-3,170	-5,170	-7,170	-9,000	-10,160	-11,350	-12,480	-13,270	-14,190	-24,510	-85,960
	Part B	0	-2,090	-3,400	-4,720	-5,840	-6,700	-7,700	-8,670	-9,560	-10,390	-16,050	-59,070
3202	Benefit Protection and Simplification	0	0	0	0	0	0	0	0	0	0	0	0
3203	Coding Intensity Adjustment During MA Payment Transition	0	0	0	0	0	0	0	0	0	0	0	0
3204	Simplification of Annual Beneficiary Election Periods	0	0	0	0	0	0	0	0	0	0	0	0
3205	Specialized MA Plans for Special Needs Individuals	0	0	0	0	0	0	0	0	0	0	0	0
3206	Extension of Reasonable Cost Contracts	0	0	0	0	0	0	0	0	0	0	0	0

Table 3—Estimated Medicare Costs (+) or Savings (–) under the Patient Protection and Affordable Care Act, as Enacted and Amended

(Amounts in millions)

Sec.	Provision	Fiscal year										Total,	
		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-14	2010-19
3207	Technical Correction to MA Private FFS Plans	0	0	0	0	0	0	0	0	0	0	0	0
3208	Making Senior Housing Facility Demonstration Permanen	0	0	0	0	0	0	0	0	0	0	0	0
3209	Authority to Deny Plan Bids	0	0	0	0	0	0	0	0	0	0	0	0
3210	Development of New Standards for Certain Medigap Plans												
	Part A	0	0	0	0	0	0	0	0	0	0	0	0
	Part B	0	0	0	0	0	-50	-70	-80	-90	-90	0	-380
1103	Savings from limits on MA administrative costs	0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE D-MEDICARE PART D IMPROVEMENTS FOR PRESCRIPTION DRUG PLANS AND MA-PD PLANS												
3301	Medicare Coverage Gap Discount Program	0	110	140	160	180	200	240	250	250	310	590	1,840
3302	Improving the Determination of Part D Low-Income Benchmark	0	90	120	130	140	140	150	170	180	190	480	1,310
3303	Voluntary De Minimus Policy for Low-Income Subsidy Plans	0	20	20	20	20	30	30	30	30	30	80	230
3304	Special Rule for Widows and Widowers Regarding Eligibility for Low-Income Assistance	0	0	0	0	0	0	0	0	0	0	0	0
3305	Improved Information for Subsidy Eligible Individuals	0	0	0	0	0	0	0	0	0	0	0	0
3306	Funding Outreach and Assistance for Low-Income Programs	45	45	45	0	0	0	0	0	0	0	135	135
3307	Improving Formularies with Respect to Certain Categories or Classes	0	0	0	0	0	0	0	0	0	0	0	0
3308	Reducing the Part D Premium Subsidy for High-Income Beneficiaries	0	-390	-590	-670	-760	-860	-980	-1,110	-1,260	-1,430	-2,410	-8,050
3309	Elimination of Cost Sharing for Certain Dual Eligible Individuals	0	0	0	0	0	0	0	0	0	0	0	0
3310	Reducing Wasteful Dispensing of Outpatient Prescription Drugs	0	0	0	0	0	0	0	0	0	0	0	0
3311	Improved Plan Complaint System	0	0	0	0	0	0	0	0	0	0	0	0
3312	Uniform Exception and Appeals Process	0	0	0	0	0	0	0	0	0	0	0	0
3313	OIG Studies and Reports	0	0	0	0	0	0	0	0	0	0	0	0
3314	Cost Incurred by AIDS Drug Assistance and HIS	0	50	70	70	80	90	100	110	120	130	270	820
9012	Elimination of deduction for Medicare Part D subsidy	0	0	0	40	100	130	170	190	190	200	140	1,020
1101	Closing the Medicare prescription drug "donut hole"	0	990	170	380	560	860	1,250	1,760	2,340	3,470	2,100	11,780
—	Reducing growth rate of out-of-pocket threshold	0	0	0	0	40	70	170	240	320	480	40	1,320
1206	Drug rebates for new formulations of existing drugs	0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE E-ENSURING MEDICARE SUSTAINABILITY												
3401	Market Basket Revisions and Productivity Adjustments												
	Skilled Nursing Facilities	0	-30	-440	-1,000	-1,560	-2,160	-2,920	-3,700	-4,530	-5,660	-3,030	-22,000
	Long-Term Care Hospitals	-10	-50	-120	-220	-340	-450	-590	-780	-980	-1,250	-740	-4,790
	Inpatient Rehabilitation Facilities	-10	-40	-130	-250	-390	-530	-700	-930	-1,180	-1,510	-820	-5,670
	Hospitals Paid Under the Inpatient Prospective Payment System	-140	-870	-2,670	-4,940	-7,630	-10,360	-13,940	-18,550	-23,510	-29,990	-16,250	-112,600
	Inpatient Psychiatric Facilities--Productivity Adjustment	-10	-30	-100	-190	-290	-400	-530	-700	-890	-1,130	-620	-4,270
	Inpatient Psychiatric Facilities--Quality Reporting	0	0	0	0	-10	-10	-10	-10	-10	0	-10	-50
	Hospice	0	0	0	-220	-450	-690	-980	-1,330	-1,700	-2,120	-670	-7,490
	Hospital Outpatient Services	0	0	-820	-1,280	-1,850	-2,460	-3,180	-4,210	-5,490	-6,970	-3,950	-26,260
	Durable Medical Equipment	0	-20	-50	-80	-110	-140	-180	-230	-280	-330	-260	-1,420
	All Other Part B Fee Schedules, Except Physicians' Services	0	-100	-300	-520	-750	-1,010	-1,310	-1,680	-2,100	-2,600	-1,670	-10,370
	Home Health--Part A	0	-60	-160	-290	-350	-440	-610	-780	-970	-1,230	-860	-4,890
	Home Health--Part B	0	-70	-180	-320	-380	-490	-680	-870	-1,080	-1,370	-950	-5,440

Table 3—Estimated Medicare Costs (+) or Savings (–) under the Patient Protection and Affordable Care Act, as Enacted and Amended

(Amounts in millions)

Sec.	Provision	Fiscal year										Total,	
		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-14	2010-19
3402	Temporary Adjustment to Calculation of Part B Premium:												
	Part B Income (additional premiums)	0	-70	-190	-320	-510	-740	-990	-1,320	-1,700	-2,300	-1,090	-8,140
	Part B Benefits	0	0	0	-10	-10	-10	-20	-20	-50	-70	-20	-190
3403	Independent Payment Advisory Board												
	Part A	0	0	0	0	0	-370	-710	-1,200	-2,010	-3,000	0	-7,290
	Part B	0	0	0	0	0	-440	-830	-1,430	-2,420	-3,680	0	-8,800
	Part D	0	0	0	0	0	-330	-670	-1,190	-2,090	-3,290	0	-7,570
10323	Medicare Coverage for Individuals Exposed to Environmental Health												
	Part A	10	10	10	10	10	20	20	20	20	20	50	150
	Part B	0	10	10	10	10	10	10	10	10	20	40	100
10324	Protection for Frontier States												
	Part A	0	190	230	250	260	280	300	320	340	370	930	2,540
	Part B	0	80	150	170	170	190	200	230	240	280	570	1,710
10325	Delay Implementation of RUG-IV	0	0	0	0	0	0	0	0	0	0	0	0
10326	Pilot Testing for Pay-for-Performance	0	0	0	0	0	0	0	0	0	0	0	0
10327	Improvments to Physician Quality Reporting System	0	0	0	110	120	140	160	0	0	0	230	530
10328	Improvments to Part D Medication Therapy Management	0	0	0	0	0	0	0	0	0	0	0	0
10329	Methodology to Assess Health Plan Value	0	0	0	0	0	0	0	0	0	0	0	0
10330	Modernizing CMS Computer and Data System	0	0	0	0	0	0	0	0	0	0	0	0
10331	Public Reporting of Performance Information	0	0	0	0	0	0	0	0	0	0	0	0
10332	Availability of Medicare Data for Performance Measurement	0	0	0	0	0	0	0	0	0	0	0	0
10333	Community Based Collaborative Care Networks	0	0	0	0	0	0	0	0	0	0	0	0
10334	Minority Health	0	0	0	0	0	0	0	0	0	0	0	0
10335	Technical Correction to Hospital Value-based Purchasing	0	0	0	0	0	0	0	0	0	0	0	0
10336	Report on Access to High-quality Dialysis Services	0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE F-HEALTH CARE QUALITY IMPROVEMENTS												
3501	Health Care Delivery System Research	0	0	0	0	0	0	0	0	0	0	0	0
3502	Support Patient-Centered Medical Home	0	0	0	0	0	0	0	0	0	0	0	0
3503	Medication Management Services	0	0	0	0	0	0	0	0	0	0	0	0
3504	Regionalized Systems for Emergency Care	0	0	0	0	0	0	0	0	0	0	0	0
3505	Trauma Care Centers	0	0	0	0	0	0	0	0	0	0	0	0
3506	Shared Decisionmaking	0	0	0	0	0	0	0	0	0	0	0	0
3507	Prescription Drug Benefit and Risk Information	0	0	0	0	0	0	0	0	0	0	0	0
3508	Demonstration to Integrate Quality Care and Patient Safety	0	0	0	0	0	0	0	0	0	0	0	0
3509	Improving Woman's Health	0	0	0	0	0	0	0	0	0	0	0	0
3510	Patient Navigator Program	0	0	0	0	0	0	0	0	0	0	0	0
3511	Authorization of Appropriations	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL, TITLE III		1,415	-3,235	-12,685	-22,020	-58,080	-48,770	-62,690	-77,850	-92,760	-110,160	-94,605	-486,835

Table 3—Estimated Medicare Costs (+) or Savings (–) under the Patient Protection and Affordable Care Act, as Enacted and Amended

(Amounts in millions)

Sec.	Provision	Fiscal year										Total	
		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-14	2010-19
	TITLE IV-PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH												
	SUBTITLE A-MODERNINZING DISEASE PREVENTION AND PUBLIC HEALTH SYSTEMS												
4001-4004		0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE B-INCREASING ACCESS TO CLINICAL PREVENTIVE SERVICES												
4103	Annual Wellness Visit Providing a Personalized Plan	0	230	380	380	390	420	470	530	590	650	1,380	4,040
4104	Removing Barriers to Preventive Services	0	110	190	200	210	230	250	270	300	330	710	2,090
4105	Evidence-Based Coverage of Preventive Services	-60	-140	-160	-170	-170	-180	-200	-220	-240	-260	-700	-1,800
	SUBTITLE C-CREATING HEALTHIER COMMUNITIES												
4201-4207		0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE D-SUPPORT FOR PREVENTION AND PUBLIC HEALTH INNOVATION												
4301-4306		0	0	0	0	0	0	0	0	0	0	0	0
	Additional Provisions	0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE E-MISCELLENEOUS PROVISIONS												
4401-4402		0	0	0	0	0	0	0	0	0	0	0	0
TOTAL, TITLE IV		-60	200	410	410	430	470	520	580	650	720	1,390	4,330
	TITLE V-HEALTH CARE WORKFORCE												
	SUBTITLE A-PURPOSE AND DEFINITIONS												
5001-5002		0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE B-INNOVATIONS IN HEALTH CARE WORKFORCE												
5102-5103		0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE C- INCREASING THE SUPPLY OF THE HEALTH CARE WORKFORCE												
5201-5210		0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE D-ENHANCING HEALTH CARE WORKFORCE EDUCATION AND TRAINING												
5301-5315		0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE E-SUPPORTING THE EXISTING HEALTH CARE WORKFORCE												
5401-5405		0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE F-STRENGTHENING PRIMARY CARE AND OTHER WORKFORCE IMPROVEMENTS												
5501	Expanding Access to Primary Care/General Surgery Services	0	170	260	260	260	270	110	0	0	0	950	1,330
5502	Medicare Federally Qualified Health Center Improvement	0	16	10	20	20	70	90	100	100	110	60	530
5503	Distribution of Additional Residency Positions	0	0	0	0	0	0	0	0	0	0	0	0
5504	Counting Resident Time in Outpatient Setting	0	0	0	0	0	0	0	0	0	0	0	0
5505	Rules for Counting Resident Time for Didactic/Scholarly Activities	0	0	0	0	0	0	0	0	0	0	0	0
5506	Preservation of Resident Cap Positions	0	0	0	0	0	0	0	0	0	0	0	0
5507	Demonstration to Address Health Professions Workforce Needs	0	0	0	0	0	0	0	0	0	0	0	0
5508	Increasing Teaching Capacity	0	0	0	0	0	0	0	0	0	0	0	0
5509	Graduate Nurse Education Demonstration Program	0	0	0	0	0	0	0	0	0	0	0	0

Table 3—Estimated Medicare Costs (+) or Savings (–) under the Patient Protection and Affordable Care Act, as Enacted and Amended

(Amounts in millions)

Sec.	Provision	Fiscal year										Total,	
		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-14	2010-19
	SUBTITLE G-IMPROVING ACCESS TO HEALTH CARE SERVICES												
5601-5605		0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE H-GENERAL PROVISIONS												
5701	Reports	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL, TITLE V		0	180	270	280	280	340	200	100	100	110	1,010	1,860
	TITLE VI-TRANSPARENCY AND PROGRAM INTEGRITY												
	SUBTITLE A-PHYSICIAN OWNERSHIP AND OTHER TRANSPARENCY												
6001	Limitation on Medicare Exception to the Prohibition on Certain Physician Referrals for Hospitals	0	0	0	0	0	0	0	0	0	0	0	0
6002	Transparency Reports on Physician Ownership	0	0	0	0	0	0	0	0	0	0	0	0
6003	Disclosure Requirements for in-Office Ancillary Services	0	0	0	0	0	0	0	0	0	0	0	0
6004	Prescription Drug Sample Transparency	0	0	0	0	0	0	0	0	0	0	0	0
6005	Pharmacy Benefit Managers Transparency Requirements	0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE B-NURSING HOME TRANSPARENCY AND IMPROVEMENT												
6101-6121		0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE C-NATIONWIDE PROGRAM FOR BACKGROUND CHECKS ON DIRECT PATIENT ACCESS EMPLOYEES OF LONG-TERM CARE FACILITIES AND PROVIDERS												
6201	Nationwide Program for Background Checks	0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE D-PATIENT CENTERED OUTCOMES RESEARCH												
6301	Patient Centered Outcomes Research	0	0	0	0	0	0	0	0	0	0	0	0
6302	Federal Coordinating Council for CER	0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE E-MEDICARE, MEDICAID, AND CHIP PROGRAM INTEGRITY												
6401	Provider Screening and Other Enrollment Requirements												
	Part A	0	0	0	0	0	0	0	0	0	0	0	0
	Part B	-10	-20	-20	-30	-30	-30	-30	-30	-40	-40	-110	-280
6402	Enhanced Program Integrity Provisions												
	Part A	0	0	-10	-20	-30	-30	-30	-40	-40	-40	-60	-240
	Part B	0	0	-10	-10	-20	-20	-20	-20	-20	-20	-40	-140
6403	Elimination of Duplication between Data Banks												
	Part A	0	0	0	0	0	0	0	0	0	0	0	0
	Part B	0	0	0	0	0	0	0	0	0	0	0	0
6404	Maximum Period for Submission of Medicare Claims to Not More Than 12 Months												
	Part A	0	60	70	70	80	80	90	100	100	110	280	760
	Part B	0	50	50	50	50	60	60	70	70	80	200	540
6405	Physicians Required to Be Enrolled Physicians												
	Part A	-10	-20	-20	-20	-30	-30	-30	-30	-30	-40	-100	-260
	Part B	-30	-50	-50	-50	-60	-60	-60	-70	-70	-80	-240	-580

Table 3—Estimated Medicare Costs (+) or Savings (–) under the Patient Protection and Affordable Care Act, as Enacted and Amended

(Amounts in millions)

Sec.	Provision	Fiscal year										Total,	
		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-14	2010-19
6406	Documentation on Referrals to Programs at High Risk of Waste and Abuse												
	Part A	0	0	0	0	0	0	0	0	0	0	0	0
	Part B	0	0	0	0	0	0	0	0	0	0	0	0
6407	Face to Face Encounter with Patient Required Before Physician May Certify for HHA or DME												
	Part A	-50	-70	-70	-80	-80	-90	-100	-100	-110	-120	-350	-870
	Part B	-70	-110	-120	-130	-140	-150	-160	-170	-180	-190	-570	-1,420
6408	Enhanced Penalties												
	Part A	0	0	0	0	0	0	0	0	0	0	0	0
	Part B	0	0	0	0	0	0	0	0	0	0	0	0
6409	Medicare Self-referral Disclosure Protocol												
	Part A	0	0	0	0	0	0	0	0	0	0	0	0
	Part B	0	0	0	0	0	0	0	0	0	0	0	0
	Adjustments to DME, Prosthetics, Orthotics, and Supplies												
6410	Competitive Acquisition Program												
	Part A	0	0	0	0	0	0	0	0	0	0	0	0
	Part B	0	-10	-20	-20	-20	-20	-80	-120	-130	-140	-70	-560
6411	Expansion of Recovery Audit Contractor (RAC) program												
	Part A	0	-20	-30	-40	-40	-40	-50	-50	-50	-60	-130	-380
	Part B	0	0	-10	-10	-10	-10	-10	-10	-10	-10	-30	-80
	Part D	0	-10	-20	-30	-30	-30	-30	-40	-40	-50	-90	-280
1301	Limit MH Center Providers												
	Part A	0	0	0	0	0	0	0	0	0	0	0	0
	Part B	0	0	-10	-10	-20	-20	-20	-20	-20	-30	-40	-150
1302	Repeal Limits on Claims Review												
	Part A	0	0	0	0	0	0	0	0	0	0	0	0
	Part B	0	0	0	0	0	-10	-10	-10	-10	-10	0	-50
1303	CMS-IRS Data Match to Find Fraudulent Providers												
	Part A	0	0	0	0	0	-10	-10	-10	-10	-10	0	-50
	Part B	0	0	0	-20	-60	-110	-130	-140	-150	-160	-80	-770
1304	Funding for Fraud and Abuse Activities												
	Part A	0	0	0	0	0	0	0	0	0	0	0	0
	Part B	0	0	0	0	0	0	0	0	0	0	0	0
1305	Enhanced Claims Review of New DME Providers												
	Part A	0	0	0	0	0	0	0	0	0	0	0	0
	Part B	0	0	-10	-10	-10	-10	-10	-20	-20	-20	-30	-110
	SUBTITLE G-ADDITIONAL PROGRAM INTEGRITY PROVISIONS												
6601	Prohibition on false Statements and Representations	0	0	0	0	0	0	0	0	0	0	0	0
6602	Clarifying Definition	0	0	0	0	0	0	0	0	0	0	0	0
6603	Development of Model Uniform Report Form	0	0	0	0	0	0	0	0	0	0	0	0
6604	Applicability of State Law to Combat Fraud and Abuse	0	0	0	0	0	0	0	0	0	0	0	0
6605	Administrative Summary Cease and Desist Orders	0	0	0	0	0	0	0	0	0	0	0	0

Table 3—Estimated Medicare Costs (+) or Savings (–) under the Patient Protection and Affordable Care Act, as Enacted and Amended

(Amounts in millions)

Sec.	Provision	Fiscal year										Total:	
		2010	20..1	2012	2013	2014	2015	2016	2017	2018	2019	2010-14	2010-19
6606	MLWA Plan Registration	0	0	0	0	0	0	0	0	0	0	0	0
6607	Permitting Evidentiary Privilege and Confidential Communication	0	0	0	0	0	0	0	0	0	0	0	0
	Additional Provisions	0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE H-ELDER JUSTICE ACT												
6701	Short Title of Subtitle	0	0	0	0	0	0	0	0	0	0	0	0
6702	Definitions	0	0	0	0	0	0	0	0	0	0	0	0
6703	Elder Justice	0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE I-SENSE OF THE SENATE REGARDING MEDICAL MALPRACTICE												
6801	Sense of the Senate Regarding Medical Malpractice	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL, TITLE VI		-170	-200	-280	-360	-450	-530	-630	-710	-760	-830	-1,460	-4,920
	TITLE IX-REVENUE PROVISIONS												
9008	Fees on Brand-Name Pharmaceutical Manufacturers & Importers	0	-1,650	-2,590	-2,720	-2,850	-2,900	-2,900	-3,640	-3,970	-3,060	-9,810	-26,280
9015	Additional hospital insurance tax on high-income taxpayers	0	0	0	-1,936	-8,090	-8,901	-9,735	-10,580	-11,504	-12,484	-10,026	-63,230
TOTAL, TITLE IX		0	-1,650	-2,590	-4,656	-10,940	-11,801	-12,635	-14,220	-15,474	-15,544	-19,836	-89,510
	TOTAL IMPACT, III-VI and IX	1,185	-2,705	-14,875	-26,346	-68,760	-60,291	-75,235	-92,100	-108,244	-125,704	-113,501	-575,075

* Estimates prepared by the Office of the Chief Actuary, Social Security Administration.

Notes: The effects of the managers' amendments, in Title X of P.L. 111-148 and in P.L. 111-152, on provisions in other titles have been incorporated with the estimates shown for those titles.
New proposals included in Title X have been grouped with the corresponding category of proposal in the estimates shown for earlier titles.
The estimates for provisions affecting Medicare Part B are net of premium offset.
The estimates for Medicare provisions that affect fee-for-service benefits also reflect interactions with payments to managed care plans.

Table 4— Estimated Federal Medicaid and CHIP Costs (+) or Savings (–) under the Patient Protection and Affordable Care Act, as Enacted and Amended, in billions

Sec.	Provision	Fiscal Year 2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total 2010-14	2010-19
	Patient Protection and Affordable Care Act (P.L. 111-148)												
	TITLE II—ROLE OF PUBLIC PROGRAMS												
	Subtitle A—Improved Access to Medicaid												
2001	Medicaid coverage for the lowest income populations	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/
	Impact of sections not affecting Medicaid expansion	$0	$0	$0	$30	$1,760	$3,010	$3,800	$4,180	$4,960	$5,780	$1,790	$23,520
2002	Income eligibility for nonelderly determined using modified gross income	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/
2003	Requirement to offer premium assistance for employer-sponsored insurance	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/
2004	Medicaid coverage for former foster care children	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/
2005	Payments to territories	0	191	764	764	930	930	930	930	930	930	2,648	7,300
2006	Special adjustment to FMAP for major disaster recovery	0	255	90	0	0	0	0	0	0	0	345	345
2007	Medicaid Improvement Fund rescission	0	0	0	0	-100	-150	-150	-150	-150	0	-100	-700
	Subtitle B—Enhanced Support for CHIP												
2101	Additional federal financial participation for CHIP	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/
2102	Technical corrections	0	0	0	0	0	0	0	0	0	0	0	0
	Subtitle C—Enrollment Simplification												
2201	Enrollment simplification and coordination with State health insurance exchanges	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/
2202	Permitting hospitals to make presumptive eligibility determinations for all Medicaid eligible populations	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/
	Subtitle D—Improvements to Medicaid services												
2301	Coverage for freestanding birth center services	0	0	0	0	0	0	0	0	0	0	0	0
2302	Concurrent care for children	15	15	15	15	20	20	20	25	25	25	80	195
2303	State eligibility option for family planning services	1	0	0	-2	-4	-6	-9	-12	-15	-18	-5	-65
2304	Clarification of definition of medical assistance	0	0	0	0	0	0	0	0	0	0	0	0
	Subtitle E—New State Options for Long-term Services & Supports												
2401	Community First Choice Option	0	0	820	1,060	1,815	2,585	3,520	3,940	4,630	5,210	3,695	23,580
2402	Removal of barriers to providing home and community-based services	25	50	80	120	170	190	215	240	270	300	445	1,660
2403	Money Follows the Person Rebalancing Demonstration	0	0	450	450	450	450	450	0	0	0	1,350	2,250
2404	Protection for recipients of home and community-based services against spousal impoverishment	0	0	0	0	125	190	215	240	270	75	125	1,115
2405	Funding to expand State Aging and Disability Resource Centers	10	10	10	10	10	0	0	0	0	0	50	50
2406	Sense of the Senate regarding long-term care	0	0	0	0	0	0	0	0	0	0	0	0
	Subtitle F—Medicaid Prescription Drug Coverage												
2501(a)(1)	Increase minimum rebate percentage for brand drugs	-240	-440	-440	-470	-500	-530	-560	-590	-630	-670	-2,090	-5,070
2501(a)(2)	Recapture of total savings	-230	-610	-680	-720	-770	-820	-870	-920	-980	-1,040	-3,010	-7,640
2501(b)	Increase rebate percentage for generic drugs	-20	-30	-30	-30	-40	-40	-40	-40	-50	-50	-150	-370
2501(c)	Extension of prescription drug discounts to enrollees of Medicaid managed care organizations	-580	-720	-720	-770	-820	-870	-930	-990	-1,040	-1,100	-3,610	-8,540
2501(d)	Rebates on new drug formulations	-110	-210	-210	-220	-230	-250	-260	-280	-290	-310	-980	-2,370
2501(e)	Maximum rebate amount	0	0	0	0	0	0	0	0	0	0	0	0
2501(f)	Conforming Amendment	0	0	0	0	0	0	0	0	0	0	0	0

Table 4— Estimated Federal Medicaid and CHIP Costs (−) or Savings (–) under the Patient Protection and Affordable Care Act, as Enacted and Amended, in billions

Sec.	Provision	Fiscal Year										Total,	
		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-14	2010-19
2502	Elimination of exclusion of coverage of certain drugs	0	0	0	0	25	30	30	40	45	45	25	215
2503	Providing adequate pharmacy reimbursement	0	135	275	290	310	325	345	370	390	415	1,010	2,855
	Subtitle G—Medicaid Disproportionate Share Hospital Payments												
2551	Disproportionate share hospital payments	0	0	0	0	-500	-600	-600	-1,800	-5,000	-5,600	-500	-14,100
	Subtitle H—Dual Eligibles												
2601	5-year period for demonstration projects	0	0	0	0	0	0	0	0	0	0	0	0
2602	Providing Federal coverage and payment coordination for low-income Medicare beneficiaries	0	0	0	0	0	0	0	0	0	0	0	0
	Subtitle I—Medicaid Quality												
2701	Adult health quality measures	40	50	60	70	80	0	0	0	0	0	300	300
2702	Payment Adjustment for Health Care-Acquired Conditions	0	-2	-4	-5	-5	-5	-6	-6	-7	-7	-15	-46
2703	State option to provide health homes for enrollees with chronic conditions	0	35	90	115	145	175	150	135	135	135	385	1,115
2704	Demonstration project to evaluate integrated care around a hospitalization	0	0	0	0	0	0	0	0	0	0	0	0
2705	Medicaid Global Payment System Demonstration Project	0	0	0	0	0	0	0	0	0	0	0	0
2706	Pediatric Accountable Care Organization Demonstration Project	0	0	0	0	0	0	0	0	0	0	0	0
2707	Medicaid emergency psychiatric demonstration project	15	15	15	15	15	0	0	0	0	0	75	75
	Subtitle J—Improvements to the Medicaid and CHIP Payment and Access Commission (MACPAC)												
2801	MACPAC assessment of policies affecting all Medicaid beneficiaries	0	0	0	0	0	0	0	0	0	0	0	0
	Subtitle K American Indians and Alaska Natives												
2901	Special rules relating to Indians	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/
2902	Permination of sunset for reimbursement for all Medicare Part B services furnished by certain Indian hospitals and clinics	0	20	20	20	30	30	30	30	30	30	90	240
	TITLE III—IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE												
	Subtitle B—Improving Medicare for Patients and Providers												
	PART III—Improving payment accuracy												
3139	Payment for biosimilar biological products - Medicaid impact	0	0	0	0	-10	-30	-50	-60	-80	-90	-10	-320
	TITLE IV—PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH												
	Subtitle A—Modernizing Disease prevention and Public Health Systems												
4004(b)	Public awareness of preventive and obesity-related services	0	0	0	0	0	0	0	0	0	0	0	0
	Subtitle B—Increasing Access to clinical Preventive Services												
4101	School-based health centers	155	200	105	115	125	135	145	160	175	190	700	1,505
4106	Improving access to preventive services for eligible adults	0	0	0	6	9	9	10	11	11	12	15	68
4107	Coverage of comprehensive tobacco cessation services for pregnant women	0	0	0	0	-10	-10	-10	-10	-10	-20	-10	-70
4108	Incentives for prevention of chronic disease	0	20	20	20	20	20	0	0	0	0	80	100
	Subtitle D—Support for Prevention and Public Health Innovation												
4302(b)	Addressing health care disparities in Medicaid and CHIP	0	0	0	0	0	0	0	0	0	0	0	0
4306	Funding for Childhood Obesity Demonstration Project	5	5	5	5	5	0	0	0	0	0	25	25

Table 4— Estimated Federal Medicaid and CHIP Costs (+) or Savings (–) under the Patient Protection and Affordable Care Act, as Enacted and Amended, in billions

Sec	Provision	Fiscal Year 2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total, 2010-14	2010-19
	TITLE VI—TRANSPARENCY AND PROGRAM INTEGRITY												
	Subtitle E—Medicare, Medicaid & CHIP Program Integrity Provisions												
6201	Background checks for certain employees of LTC facilities	0	30	20	30	30	30	30	30	30	30	110	260
6401	Provider screening and other enrollment requirements under Medicare, Medicaid & CHIP	0	0	0	0	0	0	0	0	0	0	0	0
6402	Enhanced Medicare and Medicaid program integrity provisions	0	0	0	0	0	0	0	0	0	0	0	0
6403	Elimination of duplication between the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank	0	0	0	0	0	0	0	0	0	0	0	0
6407	Face to face encounter with patient required before physicians may certify eligibility for home health services or durable medical equipment under Medicare	0	0	0	0	0	0	0	0	0	0	0	0
6408	Enhanced penalties	0	0	0	0	0	0	0	0	0	0	0	0
6111	Expansion of the Recovery Audit Contractor Program	0	-80	-170	-250	-310	-330	-360	-390	-420	-450	-810	-2,760
	Subtitle F—Additional Medicaid Program Integrity Provisions												
6501	Termination of provider participation under Medicaid if terminated under Medicare or other State plan	0	0	0	0	0	0	0	0	0	0	0	0
6502	Medicaid exclusion from participation relating to certain ownership, control, and management affiliations	0	0	0	0	0	0	0	0	0	0	0	0
6503	Billing agents, clearinghouses, or other alternate payees required to register under Medicaid	0	0	0	0	0	0	0	0	0	0	0	0
6504	Requirement to report expanded set of data elements under MMIS to detect fraud and abuse	0	0	0	0	0	0	0	0	0	0	0	0
6505	Prohibition on payments to institutions or entities located outside of the United States	0	0	0	0	0	0	0	0	0	0	0	0
6506	Overpayments	260	480	-65	-70	-75	-80	-85	-90	-95	-105	530	75
6507	Mandatory State use of national correct coding initiative	-10	-25	-40	-45	-55	-75	-85	-90	-95	-100	-175	-620
6508	General effective date	0	0	0	0	0	0	0	0	0	0	0	0
	TITLE VII—IMPROVING ACCESS TO INNOVATIVE MEDICAL THERAPIES												
	Subtitle B—More Affordable Medicines for Children and Underserved Communities												
7101(d)	Expanded participation in 340B programs - Medicaid credits	2/	2/	2/	2/	2/	2/	2/	2/	2/	2/	2/	2/
	TITLE X—STRENGTHENING QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS												
	Subtitle B—Provisions Relating to Title II												
	Part I—Medicaid and CHIP												
10202	Incentives for States to offer home and community-based services as a long term care alternative to nursing homes	0	0	800	910	1,030	260	0	0	0	0	2,740	3,000
SUBTOTAL, P.L. 111-148		*-664*	*-605*	*1,279*	*1,463*	*3,675*	*4,593*	*5,875*	*4,903*	*3,040*	*3,617*	*5,149*	*27,177*

Table 4— Estimated Federal Medicaid and CHIP Costs (+) or Savings (–) under the Patient Protection and Affordable Care Act, as Enacted and Amended, in billions

Sec.	Provision	Fiscal Year 2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total 2010-14	Total 2010-19
	Health Care and Education Reconciliation Act of 2010 (P.L. 111-152)												
	TITLE I—Coverage Medicare, Medicaid, and Revenues												
	Subtitle C—Medicaid												
1202	Payment to primary care physicians	0	0	0	3,670	5,460	1,450	0	0	0	0	9,130	10,580
SUBTOTAL, P.L. 111-152		*0*	*0*	*0*	*3,670*	*5,460*	*1,450*	*0*	*0*	*0*	*0*	*9,130*	*10,580*
	Interaction - Prescription Drugs	-190	-250	-270	-280	-300	-320	-330	-360	-390	-410	-1,290	-3,100
	Interaction - Medicaid Expansion	0	0	0	0	200	-90	-270	-300	-320	-350	200	-1,130
	Interaction with Medicare Premium Provisions	0	-70	-220	-320	-400	-520	-670	-840	-1,010	-1,140	-1,010	-5,190
TOTAL, P.L. 111-148 and P.L. 111-152, with interactions		**-854**	**-925**	**789**	**4,533**	**8,635**	**5,113**	**4,605**	**3,403**	**1,320**	**1,717**	**12,179**	**28,337**

[1] Included with Title I impacts.

[2] Insufficient detail for estimation

Table 5 — Estimated Increases (+) or Decreases (–) in National Health Expenditures under the Patient Protection and Affordable Care Act, as Enacted and Amended, in billions

	Calendar Year										Total, CY
Prior Law Baseline	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019
Total National Health Expenditures (NHE)	$ 2,632.2	$ 2,778.7	$ 2,944.4	$ 3,125.4	$ 3,325.5	$ 3,551.5	$ 3,798.5	$ 4,067.7	$ 4,358.8	$ 4,670.6	$ 35,253.3
Medicare	515.5	550.5	591.0	634.1	679.7	732.1	790.4	857.2	930.9	1,010.9	7,292.3
Medicaid/CHIP	436.1	473.0	512.4	553.4	593.9	641.7	696.6	755.9	821.7	893.2	6,377.9
Federal	282.2	277.9	292.7	315.9	337.8	364.3	395.0	427.9	464.6	504.5	3,662.8
State & Local	153.9	195.1	219.6	237.6	256.1	277.4	301.5	328.0	357.1	388.7	2,715.1
Other Public	307.7	325.1	343.9	364.6	386.6	410.5	436.4	464.0	493.2	523.6	4,055.5
Out of Pocket	285.1	297.7	308.9	322.3	340.3	359.4	379.1	400.2	422.8	446.7	3,562.4
Employer-Sponsored Private Health Insurance	847.0	879.0	919.3	966.0	1,024.5	1,088.4	1,156.0	1,228.7	1,305.6	1,387.3	10,801.8
Other Private Health Insurance*	49.2	51.0	54.6	57.7	59.4	61.5	63.5	65.9	68.2	70.6	601.7
Other Private†	191.6	202.4	214.5	227.3	241.1	257.8	276.4	296.0	316.4	338.3	2,561.8
NHE as percent of Gross Domestic Product (GDP)‡	17.8%	17.9%	18.1%	18.2%	18.6%	19.0%	19.4%	19.8%	20.3%	20.8%	

	Calendar Year										Total, CY
New Law — PPACA	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019
Total National Health Expenditures (NHE)	$ 2,636.4	$ 2,774.4	$ 2,952.7	$ 3,101.5	$ 3,358.8	$ 3,615.9	$ 3,875.2	$ 4,139.6	$ 4,413.1	$ 4,716.5	$ 35,564.0
Medicare	516.0	545.7	577.1	604.8	626.1	682.1	726.1	778.1	836.4	897.9	6,790.2
Medicaid/CHIP	434.2	471.4	513.3	557.7	657.3	716.6	779.4	832.7	900.8	977.9	6,841.4
Federal	281.2	277.4	294.5	321.1	398.3	435.7	478.2	505.6	543.8	588.7	4,122.7
State & Local	153.0	194.1	218.9	236.3	259.0	280.8	301.2	329.1	357.1	389.2	2,718.7
Other Public	312.3	325.2	344.0	364.9	381.7	406.2	434.6	463.4	493.5	523.6	4,049.4
Out of Pocket	285.1	297.9	308.6	321.6	313.6	323.9	334.7	352.5	381.4	405.8	3,325.1
Employer-Sponsored Private Health Insurance	848.2	881.0	921.3	968.3	1,038.8	1,112.3	1,160.7	1,212.2	1,259.7	1,336.1	10,738.7
Other Private Health Insurance*	49.3	50.9	54.1	57.0	14.9	14.9	14.5	14.2	13.9	13.6	297.4
Other Private†	191.4	202.3	214.3	227.2	234.8	251.9	272.8	293.4	314.5	335.6	2,538.1
Exchanges	–	–			91.7	107.9	152.4	193.1	212.8	225.8	983.7
NHE as percent of Gross Domestic Product (GDP)‡	17.8%	17.9%	18.0%	18.2%	18.8%	19.3%	19.8%	20.2%	20.5%	21.0%	

Table 5, continued — Estimated Increases (+) or Decreases (–) in National Health Expenditures under the Patient Protection and Affordable Care Act, as Enacted and Amended, in billions

	Calendar Year										Total, CY
Impact of PPACA	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019
Total National Health Expenditures (NHE)	$ 4.2	-$ 4.3	-$ 11.7	-$ 23.0	$ 33.4	$ 64.4	$ 76.7	$ 71.9	$ 54.3	$ 45.8	$ 316.8
Medicare	0.4	-4.8	-13.9	-29.4	-53.6	-50.0	-64.3	-79.1	-94.5	-115.0	-502.1
Medicaid/CHIP	-1.9	-1.5	1.0	4.3	63.4	74.8	82.8	76.8	79.2	84.7	463.5
Federal	-1.1	-0.5	1.7	5.6	69.4	71.4	83.2	75.7	79.2	84.2	459.9
State & Local	-0.8	-1.0	-0.8	-1.3	2.9	3.5	-0.4	1.1	0.0	0.5	3.6
Other Public	4.6	0.1	0.2	0.3	-4.9	-4.3	-1.9	-0.6	0.3	0.0	-6.1
Out of Pocket	-0.1	0.2	-0.3	-0.7	-26.7	-35.5	-44.4	-47.6	-41.3	-40.9	-237.3
Employer-Sponsored Private Health Insurance	1.2	2.0	2.0	2.3	14.3	24.0	4.8	-16.4	-45.9	-51.2	-63.1
Other Private Health Insurance*	0.1	-0.1	-0.4	-0.7	-44.5	-46.5	-49.1	-51.7	-54.3	-57.0	-304.2
Other Private†	-0.2	-0.2	-0.2	-0.1	-6.3	-5.9	-3.7	-2.6	-2.0	-2.7	-23.7
Exchanges	—	—	—	—	91.7	107.9	152.4	193.1	212.8	225.8	983.7
NHE as percent of Gross Domestic Product (GDP)‡	0.0%	0.0%	-0.1%	-0.1%	0.2%	0.3%	0.4%	0.3%	0.3%	0.2%	

*In the prior-law baseline, other private health insurance includes private Medicare supplemental coverage and individual coverage. In the new-law estimates, other private health insurance includes only those with Medicare supplemental coverage.

†In the NHE accounts, other private spending includes philanthropic giving and income from non-patient sources such as parking and investment income, for institutional providers.

‡Based on Gross Domestic Product (GDP) projections that accompanied the February 24, 2009 NHE projections release for 2008–2018.
(http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2008.pdf)

Source: Centers for Medicare & Medicaid Services, Office of the Actuary.
April 22, 2010

Mr. FRANKS. All right.

Mr. Chairman, I guess here is the thing I hope we are not missing here is that all of us want for there to be a way for people in crises to be able to have a bankruptcy action. I want that very much. I have never had to do that, but I have been so poor I couldn't pay the lawyers to file for bankruptcy. And so I always want that.

But we are losing sight of what we are really talking about here. We are talking about doing away with a means test, and I know the means test can sometimes be complicated. But apart from

that—and we are not talking about a catastrophic standard here—apart from that, someone like myself, you know, could under this—under this law, if I—you know, I am tall, dark and harelip.

If I decide to go out and get plastic surgery, which probably my wife might even appreciate—I don't know—or a tummy tuck or something, my insurance company wouldn't pay for that. But that would put me over the $10,000 amount. And even if I had a lot of money, I could game the system pretty significantly.

And here is the problem. I realize maybe that doesn't happen as much as a lot of people try to portray. But whenever it does, whenever there is a bankruptcy, whenever someone doesn't pay—especially if they have it—that means someone else either pays or doesn't get the care. And that is the thing here that we always miss.

We think that somehow there is just a magic way to wipe these things clean. But unfortunately, it doesn't work that way. It means that someone else is deprived of care or has to pay for it.

And I want everybody to have access to care. And I wish everybody could have free care, if it didn't mean that we had to force somebody else to pay for it. That is the problem with socialism is after a while you run out of other people's money. That is a quote I stole, but let me just quickly ask a couple of questions here.

Judge, I will ask you. Under this legislation, if I had $100,000 in credit card debt and I did my tummy tuck and my plastic surgery for $10,000, could I get rid of the $100,000 in the process?

Judge MORRIS. I don't think so, because I think both you and I, again, are under the same medical care. We also understand we have our health savings plan. They are not going to pay for your tummy tuck.

Mr. FRANKS. That is right. But I mean——

Judge MORRIS. So and I think you could be——

Mr. FRANKS. But that means I am in debt now $10,000, because I didn't want to pay for it either. And so I am coming to you——

Judge MORRIS. But you are not going to get a medical—you are not going to get a medical reprieve for that.

Mr. FRANKS. Well, I am saying, what would change that? I mean, that is money I owe for medical care, and there is nothing in this legislation that says it can't be a tummy tuck.

Judge MORRIS. I don't think that is called medical care, but I will let you legislate that.

Mr. FRANKS. All right. Well, I would challenge the majority to counter that, if that is true.

Let me suggest to you—ask you also, then. If I lived with someone, if my wife lost her income for 4 weeks in the last 3 years, would that qualify me under this?

Judge MORRIS. I don't know the answer to that.

Mr. FRANKS. Well, I am suggesting to you the answer is yes, according to the law.

And I am just saying, Mr. Chairman, that—and I am done here—the bottom line is that we all want a bankruptcy to be there for those people who desperately need it, and I know that happens. But we don't want to have a system that just says all you have to do is to come up with $10,000, and you can game the system, and

in the process make either somebody else pay for it or deprive someone else of medical care.

Let us help those who really need it, and let us don't let this socialist train keep roaring down the track and absolutely decimate everybody long-term.

And with that, I yield back.

Mr. COHEN. Thank you, Mr. Franks. I appreciate you cutting your questions short and Mr. Johnson for yielding, as I have corrected Ms. Chu, because we do have votes.

I would like to thank all the witnesses for their testimony today. Without objection——

Mr. JOHNSON. Oh, oh, oh, Mr. Chairman, no, I didn't yield. If I could have——

Mr. COHEN. Mr. Johnson, quickly, because we got a vote.

Mr. JOHNSON. Yes, I feel compelled.

Mr. COHEN. Sorry. I got the wrong information.

Mr. JOHNSON. Okay. All right.

The Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 was a revision to bankruptcy law so that it would make it more difficult for consumers to avoid payment of credit card debt. Isn't that correct, Dr. Mathur?

Ms. MATHUR. The 2005 law was to prevent against exploitation of the system by high-income borrowers who have the ability to repay that debt, but were still filing——

Mr. JOHNSON. By high-end borrowers, you say?

Ms. MATHUR. By high-income borrowers.

Mr. JOHNSON. High-income, but it——

Ms. MATHUR. Who had the ability to repay.

Mr. JOHNSON [continuing]. Mostly affects, though, lower income individuals——

Ms. MATHUR. No, I don't think that is true, though.

Mr. JOHNSON [continuing]. Middle-class people.

Ms. MATHUR. I don't think that is true, though, because as Professor Wright, I am sure——

Mr. JOHNSON. Well, let——

Ms. MATHUR [continuing]. Will agree that a lot of people who were earlier able to file under Chapter 7 are still able to do so.

Mr. JOHNSON. Well, let me ask Judge Morris, who practices in this area daily as a bankruptcy judge.

Judge, how long have you served in bankruptcy court?

Judge MORRIS. Well I have been a judge for 10 years.

Mr. JOHNSON. And——

Judge MORRIS. And before that I was the clerk of the court in Georgia.

Mr. JOHNSON. Okay.

Judge MORRIS. And in New York. I know. It is a difficult move, but I did it.

Mr. JOHNSON. Yes, yes. Well, that is all right. Did you have experience under the old bankruptcy law?

Judge MORRIS. No, actually, I did not. I did not practice bankruptcy law at the time. But what I did practice was family practice.

Mr. JOHNSON. I see.

Judge MORRIS. I had a domestic practice, so I do understand, and sent some people to bankruptcy lawyers, so, yes, I know a lot about that.

Mr. JOHNSON. Okay.

Judge MORRIS. And one thing I saw is the means test could have possibly been corrected, if you had just simply changed the exemption in five states.

Mr. JOHNSON. Well, exemptions in Georgia, by the way, are quite puny.

Judge MORRIS. Exactly. Same thing in New York. As the law was coming into effect, New York State changed their law. It was only 10,000 in equity in a home, and they changed it to 50,000 in response to the law.

Mr. JOHNSON. I think Georgia was——

Judge MORRIS. No bankruptcy person had anything to do with it.

Mr. JOHNSON. Yes. I think Georgia was—and still is—$7,500 equity.

Judge MORRIS. But basically, you would have gotten rid of most of the, I think, at least from what I hear, if you just change the five states that had unlimited amount.

Mr. JOHNSON. So this is an ant being killed by a sledgehammer by their 2005 so-called Abuse Prevention and Consumer Protection Act.

But isn't it a fact that in your testimony, Ms. Mathur—Dr. Mathur, you state that it is surprising that the Medical Bankruptcy Fairness Act focuses on medical debt to the exclusion of other debtors in the current economic climate? You state that. And are you suggesting that this bill should be expanded to other types of debtors?

Ms. MATHUR. I am suggesting that the reason why you are having hearings on this bill is because of the Himmelstein studies, and if we did not have those studies, which are flawed, then we would not be sitting here.

Mr. JOHNSON. And should medical debt, though, get special treatment, especially since Americans, due to no fault on their own, fall victim to sickness and disease?

Ms. MATHUR. There are debtors who are in bankruptcy for no fault of theirs, the people who are losing jobs, the people who are going through painful divorces. And we need a policy that either helps all of them, which I think the current bankruptcy code does, and we don't need this bill.

Mr. JOHNSON. Well, you know, perhaps high-cost or high-income individuals, million-dollar homes, that kind of thing, may not need it, but certainly working people who may be overextended on credit for whatever reason, whether or not it was for a pair of shoes or whether or not it was to pay a medical bill for a doctor for treatment that they need on an ongoing basis to remain able to pay the bills——

Ms. MATHUR. Absolutely. And I think——

Mr. JOHNSON. And I just think that we need to have some heart for regular working people, who get caught up in the economic conditions that they did not create.

Ms. MATHUR. Absolutely. And I think those kind of people will be helped—are being helped under the current code.

Mr. JOHNSON. Well, I take exception, and I believe that people are being hurt. Even if you can't go to court unless you have an attorney, you cannot pro se file anymore for—and get accomplished in bankruptcy what you could have prior to the 2005 changes. You have got to go through a lawyer, and then even lawyers are not capable, some of them, of having the proper tools to produce a satisfactory result in bankruptcy court.

So with that I will conclude. Thank the witnesses for coming.

And, Professor, I appreciate the work that you do with your indigent persons.

Thank you.

Mr. COHEN. I thank all the witnesses. Without objection, Members have 5 legislative days to submit additional questions. You will have the opportunity to respond to them, and I hope you will do them promptly as possible. They will be part of the record.

Without objection, the record remains open for 5 legislative days for submission of any other additional materials.

Thank everybody for their time and patience. The hearing of this Subcommittee is adjourned, and we will vote. Thank you.

[Whereupon, at 1:28 p.m., the Subcommittee was adjourned.]

APPENDIX

MATERIAL SUBMITTED FOR THE HEARING RECORD

RESPONSE TO POST-HEARING QUESTIONS FROM THE HONORABLE CECELIA G. MORRIS, UNITED STATES BANKRUPTCY JUDGE, SOUTHERN DISTRICT OF NEW YORK

Questions for the Record
Subcommittee on Commercial and Administrative Law
Hearing on H.R. 901, the "Medical Bankruptcy Fairness Act"
July 15, 2010

The Honorable Cecelia G. Morris, United States Bankruptcy Judge, Southern District of New York

Questions from the Honorable Henry C. "Hank" Johnson, Jr.

1. **Approximately what percentage of your cases involve parties who come into your courtroom to file bankruptcy because of medical debt?**

   It is difficult for me to give statistics on how many of my cases involve medical debt because often I do not know. The first time I am aware that a debtor may have a serious medical problem is when they are before me for an appearance in my courtroom. Medical debt is often not listed on a bankruptcy petition because most debtors go to great lengths to ensure that their doctors' bills are paid. Because of this, the monetary value of their medical debt is concealed from me. Once the debtor is standing in front of me, however, these hidden struggles can become visibly apparent. And although I cannot quote statistics to you, I hope that my experiences help to convey the pervasiveness of this problem.

   I have had debtors make mandatory court appearances in the midst of battling cancer or other debilitating diseases. These debtors come to court at their sickest. I have confirmed plans of debtors whose businesses declined because their attention was focused on an elderly and ailing parent for whom they were the sole caretaker. Often times, these family members sit in the gallery during the debtors hearings because they are unable to be left home alone and the debtors cannot afford alternate care. I have witnessed these and many similar situations yet, I am sure that there are some sick debtors or overburdened caregivers of whose plight I am never made aware. It is for these debtors, known and unknown, that I believe the Medical Bankruptcy Fairness Act is imperative.

2. **Please explain why it is important to exempt medically stressed debtors and caregivers from the means test?**

   During my ten years on the bench, I have seen debtors who could not continue working either due to their own medical problems or those of loved ones. Losing a job not only cuts off a person's income source but also one's health insurance coverage. Those who lose their employment because of medical problems are then forced to enroll in COBRA insurance coverage which is usually more expensive than what they were paying for insurance coverage while they were employed; so healthcare costs increase at the same time that income is dramatically reduced.

Medically stressed debtors come before my court through no fault of their own. They do not file bankruptcy because of overspending or poor financial planning. Medical debt occurs in a variety of cases and can be just as much of a problem for those who have health insurance as those who do not. Exempting these medically stressed debtors from the means test, affords them the benefits of chapter 7.

3. **In your experience as a bankruptcy judge, what happens when individuals who are not able to qualify for Chapter 7 bankruptcy due to medical debt? For example, do you find that these individuals lose their homes, cars, or other basic necessities?**

Yes! Medically stressed debtors often grapple between staying current on their chapter 13 responsibilities and fulfilling their responsibilities to insurance companies and doctors. In my experience, those medically stressed debtors who are in chapter 13 have difficulty confirming and completing a plan, and obtaining a discharge. Although many debtors in chapter 13 have difficulty sustaining their payments to the trustee over the life of a plan, for medically stressed debtors it can be even more difficult. Unlike people who file bankruptcy due to poor financial planning, medically stressed debtors cannot just stop spending and reorganize their finances after a petition is filed. They may still be in need of medical care and be in-and-out of hospitals. They continue to incur post-petition medical bills due to doctors' visits and drug costs. They must keep current on these post petition medical bills while making payments to the chapter 13 trustee or risk dismissal of their case. Concurrently, a medically stressed chapter 13 debtor may have to fight creditors on post-petition collection issues or motions to lift the automatic stay.

All of this is occurring while the bankruptcy court is mandating that they appear at the meeting of creditors or confirmation hearings. Then, even if they make it past confirmation, they face the risk of their health deteriorating or medical costs increasing to the point that it is impossible for them to complete the plan. Despite being current with the chapter 13 trustee for years, they may be denied a discharge or have their case dismissed and continue to owe all their prepetition debts if they fail to complete the plan. On the other hand, if these debtors could qualify for chapter 7 relief, they could obtain a less time consuming and less expensive discharge making it more likely that they obtain a fresh start and stay current on any post-petition medical bills.

4. **In your written testimony, you state that bankruptcies caused by medical debt are more serious than academic research suggests. Please explain why this is the case.**

Medical debt is often hidden and therefore difficult to assess from the simple filing of a petition. Although a hospital or pharmaceutical debt may be listed in a petition, doctors' bills usually are not. Most doctors expect cash payments prior to providing care and in my experience, many debtors will pay their doctors using any money that they have access to, including using equity in their homes and retirement accounts, in order to make those payments. Unfortunately, this stretches their regular household budget thin and

forces them to use credit cards or other credit lines in order to buy groceries and pay other bills.

In addition to actual medical bills, medically stressed debtors or caregivers incur secondary medical costs for things such as heating pads, vaporizers, or other medical equipment and devices. They may also need to hire caregivers for themselves or for members of their family and remodel their homes in order to make them handicap accessible. On a petition, these costs may show up in the form of ordinary credit card debt or materialize as grocery and fuel charges.

In my opinion, a study that purports to measure medical debt would have difficulty determining what costs are actually related to a medical problem and which are not. In fact, when a petition is filed, the debtor may not even perceive medical debt to be the cause of his filing because he may not have any outstanding medical bills and he may not associate the cost of a heating pad or other ancillary medical item with his other medical debts.

5. **What do you think will happen if Congress does not step in and legislate in this area?**

In my experience, medical problems cause a great deal of stress and insolvency for people regardless of their income level or insurance coverage. If Congress does not legislate in this area, medically stressed debtors will continue to have difficulty completing a bankruptcy plan and receiving a fresh start.

6. **Please explain how the Medical Bankruptcy Fairness Act would help individuals and families that come into your courtroom.**

The Medical Bankruptcy Fairness Act gives medically stressed debtors and caregivers the ability to stay in their homes and close their bankruptcy cases faster so that they may focus more attention on recovery.

By exempting medically stressed debtors and caregivers from the means test, the Medical Bankruptcy Fairness Act makes it possible for them to file a chapter 7, which has lower costs, fewer court appearances, and offers faster relief.

The proposed increase to the homestead exemption also makes it possible for medically stressed debtors to stay in their homes. In my experience, debtors with medical problems come to bankruptcy court as a last resort. By the time their petition is filed, they have already used most of the equity in their homes and emptied retirement accounts in order to pay their medical bills. Those with medical problems are faced with enough stress and should not have to worry about a foreclosure sale on their house. Unlike others who are forced to move due to financial reasons, a move for medically stressed debtors could mean having to change doctors or hospitals with whom they have a personal relationship. Allowing medically stressed debtors and caregivers to claim a larger homestead exemption makes it more likely that they will be able to stay in their home and avoid the stress of relocation.

7. Please respond to Aparna Mathur's assertion that medical debt should not be a significant factor in raising consumer bankruptcies.

I find the assertion that medical debt has not led to an increase in consumer bankruptcies hard to believe because I have witnessed many people saddled with hidden medical debts in my courtroom. In my experience, it has been difficult to determine when a debtor is in bankruptcy due to medical debts; I have seen many debtors who show no signs of medical problems on their petitions or in any other filings with the court.

There is no question in my mind that medically stressed debtors and caregivers are being punished by the means test even though their financial problems occurred through no fault of their own. Therefore, even if it could be proven that medical debt does not account for the rising number of consumer bankruptcies, it remains unconscionable to allow those saddled with medical problems to lose their employment, their homes, and their retirement funds without the possibility of a fresh start.

Whether there are hundreds or thousands of medically stressed debtors filing bankruptcy, the exact count is inconsequential. The Supreme Court has emphasized that the purpose of bankruptcy law is both public and private in nature "in that it gives to the honest but unfortunate debtor . . . a new opportunity in life and a clear field for future effort, unhampered by the pressure and discouragement of preexisting debt." *Local Loan Co. v. Hunt*, 292 U.S. 234, 244 (1934). The idea that even one medically stressed debtor or caregiver would be forced to face the unintended consequences of BAPCPA goes against the very foundation of bankruptcy law.

8. Please respond to Aparna Mathur's assertion that the current law adequately accommodates the claims of those debtors saddled with medical debt.

The assertion that the current law accommodates those saddled with medical debt seems disingenuous in light of the fact that under the current Bankruptcy Code medically stressed debtors and caregivers are obligated to perform plans that take years to complete and may be forced to sell their homes or forgo expensive medical procedures in order to do so. This paradoxical situation could not be what our forefathers envisioned when they drafted bankruptcy into the Constitution. Medically stressed debtors come to the bankruptcy court through no fault of their own, at a time when their needs are greatest, and usually as a last resort. The Medical Bankruptcy Fairness Act removes two major hurdles to discharge—the means test and the state-by-state homestead exemptions—so that those most deserving a fresh start have a better chance of achieving one.

RESPONSE TO POST-HEARING QUESTIONS FROM APARNA MATHUR, PH.D., RESIDENT SCHOLAR, AMERICAN ENTERPRISE INSTITUTE

Questions for the Record
Subcommittee on Commercial and Administrative Law
Hearing on H.R. 901, the "Medical Bankruptcy Fairness Act"
July 15, 2010

Dr. Aparna Mathur, American Enterprise Institute

Questions from the Honorable Henry C. "Hank" Johnson, Jr.

1. **In your written testimony, you state that it is surprising that the Medical Bankruptcy Fairness Act focuses on medical debt to the exclusion of other debtors in the current economic climate. Are you suggesting that this bill be expanded to other types of debtors? Shouldn't medical debt get special treatment, especially since Americans can fall ill due to no fault of their own? Isn't this different from credit card or car loan debt that an individual voluntarily takes on?**

Response:

R1. I would like to make two points in response to this question. First, I believe that the urgency to tackle the medical bankruptcy issue through the Medical Bankruptcy Fairness Act is coming from the striking results of the Warren et al. studies that more than 50 percent of bankruptcies in the U.S. are due to medical bills. In my written testimony, I make a strong case against this hypothesis. I believe that the studies are flawed and there is no real evidence to show that medical debts have increased tremendously over the last decade as a share of total incomes. The reason this matters is that if we are mis-diagnosing the problem-if we are saying that medical debts are the largest single factor responsible for bankruptcies, when in fact, something like involuntary unemployment is, then the solutions we come up with will be equally mis-targeted. We cannot afford to make those mistakes today when people need help urgently. Second, if we believe that medical debts are involuntary, and therefore people who incur these debts need more protection, that's not a strong case by itself. Today there are millions of people who are jobless or homeless due to situations beyond their control. What is the dividing line for helping someone or not helping someone? In times of crisis such as today, our government needs to be more effective at providing help, not less. And to do that, we need solutions that work for the majority of the population. So a correct diagnosis of the problem is extremely important.

2. **What could Congress change about this bill to improve it and make it better?**

Response:

R2: By allowing people with a certain level of medical debts to walk away from all their other debts as well, I believe that the medical bankruptcy fairness act is opening itself to abuse. One way to change it would be to only allow individuals a debt discharge on their medical debts, rather than their total debts. For all other debt, they should be made to file bankruptcy through the usual process.

3. **One of the issues you have with the Medical Bankruptcy Fairness Act is the definition of "medically distressed debtor." In your written testimony, you state that this definition is open to abuse and fraud. Because of the detrimental effects a bankruptcy can have on one's credit report, the embarrassment associated with a**

bankruptcy, and ability to secure a loan after filing for bankruptcy, is this really a valid concern?

Response:

R3: I am afraid it is. I am going to quote from a recent paper by Elijah M. Alper in Columbia Law Review (http://www.columbialawreview.org/assets/pdfs/107/8/Alper.pdf)

"This rise in the number of bankruptcies is especially troubling because many of the new filers are not actually financially distressed. Instead, these opportunistic debtors utilize bankruptcy as a convenient means to rid themselves of their debts, while sheltering nearly all of their assets through exemptions.[73] The most blatant opportunistic bankruptcies use unlimited homestead exemption states to shield millions worth of assets in an expensive house before filing.[74] Several notable national figures, presumably quite wealthy, have taken advantage of liberal bankruptcy exemptions.[75] Even more troubling are instances of wealthy individuals successfully using bankruptcy to evade civil or even criminal sanctions.[76] Such asset protection tactics are not limited to the extremely wealthy; an entire field of "prebankruptcy planning" exists, with an aim to allow debtors to retain as many assets as possible through the bankruptcy process.[77] Prebankruptcy planning is understandable[78] when debtors declare bankruptcy due to genuine financial hardship.[79] It is less palatable when used by opportunistic debtors to avoid debts they could easily repay over time. A General Accounting Office study estimates that each year about 400 homeowners in Florida and Texas[80]—all with over $100,000 in home equity—use unlimited exemptions to shelter about $120 million from creditors.[81] One study estimates that about 4,500 households each year move to high-exemption states specifically for bankruptcy-related reasons.[82] The problem is a national concern not confined to Florida, Texas, and the other unlimited exemption states—injured creditors, after all, can be located anywhere.[83]

73. See Michelle J. White, Abuse or Protection?, Regulation, Fall 2006, at 28, 29 [hereinafter White, Regulation] ("[Opportunistic debtors] plan in advance to maximize their gains from bankruptcy. They often have high incomes and borrow as much as possible. They may have substantial assets, but they shelter the assets from the obligation to repay.").

74. For several examples of notable bankruptcy abuses, see H.R. Rep. No. 106-123, at 378–79 (1999) (stating additional dissenting views of several members discussing proposed 1999 bankruptcy reform act).

75. See, e.g., Larry Rohter, Rich Debtors Finding Shelter Under a Populist Florida Law, N.Y. Times, July 25, 1993, at 1 (describing debtors who have taken advantage of Florida's "broad and increasingly controversial network of legal exemptions from bankruptcy claims that have led [the state] to be dubbed 'the deadbeat's haven' and 'the debtor's paradise'"); Philip Shenon, Home Exemptions Snag Bankruptcy Bill, N.Y. Times, Apr. 6, 2001, at A1 ("[S]everal . . . celebrities have sought bankruptcy in Florida and Texas in recent years and held onto large homes."); Karen Hartline, How Celebrities Go Bankrupt, at http://www.legalzoom.com/articles/article_content/article13629.html (last visited October 16, 2007) (on file with the *Columbia Law Review*) (noting that several public figures declared bankruptcy with millions in assets and still retained large homes).

76. For example, WorldCom founder John Porter purchased a $17 million Florida home in 1998, despite owing more than $25 million in back taxes, and filed bankruptcy to shield his home from creditors. See Light & Warren, supra note 67 (discussing Porter filing). Wall Street raider Paul Bilzerian declared bankruptcy twice, most recently in 2001, to keep his lucrative homestead and avoid hundreds of millions of dollars in debt and millions more in civil judgment liability. See Corporate Raider Seeks Bankruptcy Again, N.Y. Times, Jan. 6, 2001, at C2 (discussing Bilzerian filings).

77. See Lawrence Ponoroff & F. Stephen Knippenberg, Debtors Who Convert Their Assets on the Eve of Bankruptcy: Villains or Victims of the Fresh Start?, 70 N.Y.U. L. Rev. 235, 265–68, 291–92 (1995) (examining judicial and academic views of prebankruptcy planning techniques).

78. See id. at 242 ("[T]he very existence of statutory exemptions reflects a deliberate policy choice to tolerate this type of 'legal fraud' in order to further even more important social interests.").

79. Not all of this hardship is undeserved. Opportunistic debtors can also include individuals facing large tort judgments, or even people of modest means who purposely run up huge credit card debts without any intention of repaying them. Precise figures are difficult to come by, but it appears that the percentage of such opportunistic filers is "fairly small." White, Regulation, supra note 73, at 31.

80. These individuals could have just as easily bought property in South Dakota, Iowa, or any other unlimited homestead state. See supra note 67.

81. 147 Cong. Rec. 3722 (2001) (statement of Sen. Kohl).

82. Elul & Subramanian, supra note 51, at 235 (stating that "slightly less than 1% of moves to states with higher exemption limits are found to be motivated by considerations of differences in bankruptcy laws"). But see 147 Cong. Rec. 3722 (citing unnamed Brown University study placing this figure at three percent).

83. See Zywicki, Bankrupt Criticisms, supra note 5 (stating that victims of opportunistic bankruptcy abuse "include every American who is forced to pay more for credit, goods, and services, because others file bankruptcy and walk away from debts they could pay but choose not to").

RESPONSE TO POST-HEARING QUESTIONS FROM PETER S. WRIGHT, JR., DIRECTOR OF CLINICAL PROGRAMS, CONSUMER AND COMMERCIAL LAW CLINIC, FRANKLIN PIERCE LAW CENTER

Questions for the Record
Subcommittee on Commercial and Administrative Law
Hearing on H.R. 901, the "Medical Bankruptcy Fairness Act"
July 15, 2010

Mr. Peter S. Wright, Director of Clinical Programs, Consumer and Commercial Law Clinic, University of New Hampshire School of Law. (formerly Franklin Pierce Law Center)

Questions from the Honorable Steve Cohen, Chairman

1. **Please respond to Dr. Mathur's contention that H.R. 901 will open the doors to strategic and abusive behavior by medical debtors because of its overly generous definition of "medically distressed debtor," the increased homestead exemption, and the means test waiver.**

   In those cases which I have handled where debtors face medical costs in excess of $10,000, there is usually a very serious medical condition driving the medical costs. As expensive as medical care can be, it is hard to imagine an individual "faking" a serious enough medical condition that any licensed medical professional would needlessly deliver in excess of $10,000 of medical care. I believe that is why we have professional medical utilization review. It is hard to imagine how a debtor could "fake" a medical problem requiring $10,000 or more in medical treatment.

2. **Please respond to the contention that H.R. 901 is not needed in light of the enactment of health care reform.**

   Even when universal healthcare coverage is available, there will always be those who fail to pay their premiums and forfeit coverage, or are unable to pay the coinsurance and deductibles. Either of those eventualities can produce an insurmountable financial challenge to an individual or family. Additionally, there is a substantial delay before the universal coverage becomes available; perhaps 2014.

3. **Would you agree that it is in the public's interest to ensure that those who have spent a lifetime diligently accruing equity in their homes as a financial "nest egg" deserve to have that equity protected in the face of mounting medical costs?**

   A central tenet of our bankruptcy system is providing the debtor with a fresh start. Most of the individuals and families who have substantial equity in their homes are senior citizens have worked all their lives to accrue it. If the cost of obtaining a fresh start is the loss of their home as they are about to retire, the promise of a fresh start is no more than an illusion.

Qnestions from the Honorable Henry C. "Hank" Johnson, Jr.

1. **Have there been any instances where your clients truly deserved Chapter 7 bankruptcy protection, but were pnshed into Chapter 13 because of means testing? If so, please explain how it affected those clients.**

   Because the clients my clinic serves must have low income to be eligible for our free services, I have not had a client forced into a Chapter 13 because of means testing. Thus, I am unable to provide insight into this problem.

2. **Approximately what percentage of your clients file bankruptcy because of medical debt?**

   I would say a solid 20% of the bankruptcies we file are for people whose immediate family either incurred uninsured medical indebtedness, or went without regular income because of sickness or injury, or because the wage earner had to care for a family member facing a catastrophic accident or illness. The added expense or loss of income often forces such a family into bankruptcy. Many of our bankruptcies come about because the family lost their home to foreclosure because of the snowball effect of medical debt, credit card debt and loss of income. Medical debt is frequently a significant factor, even if not the sole cause.

3. **In yonr written testimony, yon state that medical debt related to serious and long-term illness can push a family into bankruptcy even when the family has health insurance coverage. Please explain why this is the case.**

   Even when health insurance coverage is available, the extent of coverage may be insufficient to pay all the medical bills related to a particular medical problem. There is also the problem of coinsurance and deductibles which can impose a substantial financial burden. Aside from medical coverage, the fact that one or more of the wage earners in the family must stop working to care for a family member facing a catastrophic medical condition can also drive a family to bankruptcy because of the interruption of income. Under the definition of "medically distressed debtor" in the act this situation would be covered.

4. **Please explain how the Medical Bankrnptcy Fairness Act would help yonr clieuts.**

   I believe the primary benefit would be the enhancement of the homestead exemption in those states where the state homestead exemption is substantially below the $250,000 set out in the Medical Bankruptcy Fairness Act. With a more generous homestead amount, elderly debtors on fixed incomes who own homes with substantial equity could benefit from the fresh start of bankruptcy without losing their homes.
   The relief from having to deal with the means test is actually incidental to the substantial benefit of the enhanced homestead. I think in many cases of true medical bankruptcy, the means test will not even come into play because the debtors will have been without

sufficient income for a considerable period of time before filing anyway. My experience is that most people who are not able to pass the means test will have had medical insurance and may not fall into the definition of medically distressed debtors.

5. **Is there anything you would change to improve the bill?**

I don't think so. The bill was very carefully crafted and narrowly drawn to accomplish its intended benefits. It is noteworthy that a $250,000 homestead exemption will not permit a debtor with an extravagant home to game the system. That is, if someone has a home with $800,000 of equity, they will still have to sell their home in bankruptcy to obtain a discharge. Thus, the "high rollers" will not be able to benefit from this provision. But the debtors with modest homes and incomes should be amply protected in the event of medical catastrophe. In today's marketplace a $250,000 home is modest.

6. **Please discuss the problems with the current system of homestead exemption amounts, which often vary from state to state, and the detrimental effects on individuals where states can opt out of the federal homestead exemption.**

Many states have a shockingly low homestead exemption. It is hard to understand the benefit of a homestead exemption in the range of $20,000 to $50,000 when the value of so many homes is well above $100,000. In those states which only offer paltry homestead protection to their residents, the Medical Bankruptcy Fairness Act will provide a generous and meaningful floor of protection in the event of bankruptcy for a medically distressed debtor.
The current federal bankruptcy homestead exemption is only $20,200, which is likewise inadequate. In any case where the citizens of a state must rely upon an inadequate state homestead exemption, or the $20,200 federal exemption, the Medical Bankruptcy Fairness Act will provide a meaningful protection for the debtor who must file bankruptcy because of unmanageable medical debt.

7. **Please respond to Aparna Mathur's assertion that medical debt should not be a significant factor in raising consumer bankruptcies.**

I respectfully disagree with Dr. Mathur's assertion on this point. I believe she is overlooking the circumstances of a family whose principal wage earner loses a job or loses income while caring for a close relative struggling to surmount a medical catastrophe. Her position also overlooks the reality that an interruption of income or increased medical expenses will disrupt a family's budget with a snowball effect. Whether facing loss of income or increased medical expense, a family's budget will be thrown out of balance so that car or mortgage payments will not be paid. This snowball effect often pushes families or individuals into bankruptcy.

8. Please respond to Aparna Mathur's assertion that the current law adequately accommodates the claims of those debtors saddled with medical debt.

For the reasons already discussed it should be clear that the lack of an adequate homestead exemption in many states is a severe impediment to those debtors needing bankruptcy relief for a fresh start. For the debtor living in a state with an inadequate homestead exemption, bankruptcy relief is only available if the debtor with equity in the home is willing to lose the home. This can be particularly devastating for the elderly debtor who has worked her entire life to pay off the home so she can have a modest retirement.

○